An ethnographic study of psychiatric ward life: Exploring experiences of restrictive practices from the perspectives of patients and staff.

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Inpatient acute mental health services provide care for individuals experiencing a mental health crisis. Restrictive practices such as seclusion, physical restraint and forced medication are often used in this setting however, there is currently a focus within policy to reduce these practices due to the aversive impact they can have on patients and staff.

Part 1 of this thesis is a conceptual introduction which introduces key terms and concepts relevant to the study. It then provides a review of relevant literature exploring experiences of restrictive practices in the inpatient setting, including the environment of the ward; coercion; coercion and the therapeutic relationship; risk management; and positive experiences. The introduction highlights gaps in the literature, including a need for more UK based research and research that allows an inclusion of all practices that are experienced as coercive by patients, rather than focusing solely on the most restrictive of interventions such as seclusion, restraint and forced medication. It also provides a rationale for the study and methodological approach taken.

Part 2 is a qualitative study exploring the experience of restrictive practices from the perspectives of patients and staff situated within an adult inpatient acute mental health hospital. Ethnographic methods were adopted including semi-structured interviews, fieldwork observations and document analysis. Thematic analysis was used to analyse the data gathered. Both patients and staff constructed restrictive practices as rationalised through the need to assess risk and ensure a safe environment. However patients and staff reported negative consequences in relation to the experience of restrictive practices on the ward, whereby both patients and staff experienced a transformation in their subjectivities, with patients feeling treated as

'prisoners' and staff feeling viewed of as 'uncaring' by patients. Staff were identified as attempting to adopt more humane approaches to reduce the need for restrictive practices, such as methods of de-escalation. However these techniques were experienced by patients as being coercive. Part 2 concludes that further research is required to understand this difference in the experience of de-escalation methods. Clinical and research implications are outlined, including the potential to inform future training programmes, for example through increasing transparency in the way in which staff deliver these interventions. Implications outlined also consider the role in shaping policies regarding the use of these interventions and the reduction of restrictive practices.

Part 3 is a reflective account of the process of undertaking the study that considers the background of the researcher and ethical dilemmas experienced during the data collection as well as reflections on the methodological approaches utilised in the study.

Impact Statement

Part 1 of this thesis presents a review of the literature that identifies restrictive practices as having negative consequences for both patients and staff. It also highlights gaps in the literature surrounding the impact of restrictive practices in the inpatient mental health setting. The need for further research undertaken in the UK context is identified, which has implications for shaping future research and development of policy.

Part 2 of the this thesis provides a contemporary exploration of experiences of restrictive practices from the perspectives of both patients and staff. The findings from this study present numerous implications for clinical practice. One key finding was that the use of de-escalation methods were experienced differently by patients and staff, where for staff they were conceptualised as forming more humane methods to prevent the need for restrictive practices, whereas for patients, these practices were at times experienced as coercive ways for staff to gain compliance from the patient. Clinically, this has significant implications for the delivery of care in this setting. It is suggested that training could be developed that addresses this issue with the aim of improving the experience of care for patients. A further impact that this finding has is in supporting the need to utilise co-production in the design and evaluation of practices used in this setting. The discipline of clinical psychology may be well placed to utilise the results from this study to inform the development of interventions aimed at supporting staff with the delivery of care in this setting, for example in the facilitation of reflective practice groups that provide a space for reflection on the use of restrictive practices. It may also be beneficial to introduce opportunities for patients and staff to hear each other's experience of restrictive

practices, to share learning and improve the experience of receiving or delivering care. This could be facilitated through Community Meetings on the wards.

The dissemination of these results to the senior management team of the hospital that took part in the research could further enhance service developments to improve the experience of care from both the perspective of patients and of staff. The results could also be disseminated nationally to other services that also provide care that utilises restrictive practices.

These findings also have implications within academia. This study has highlighted the different ways in which practices are experienced as coercive and has identified the need to ensure that the individual's perspective is included in a consideration of practices deemed to be restrictive or coercive. Future research therefore could be enhanced by adopting a similar approach, to ensure that all practices that are experienced as restrictive are analysed.

Finally, the findings from this study could be disseminated within government, to inform the development of policies aimed at outlining best practice guidelines regarding the prevention and use of restrictive practices in the inpatient acute mental health setting. Attending conferences and producing documents summarising the findings in an accessible way suitable to being distributed to relevant government officials, such as Members of Parliament could also support the dissemination of the findings.

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Part 1: Conceptual Introduction

What are restrictive practices and how are these practices experienced by members of acute inpatient psychiatric wards?

Abstract

The delivery of mental health care within the inpatient setting has long attracted criticism and debate (Rogers & Pilgrim, 2010), in part due to issues surrounding the use of compulsory care and coercion in the treatment of mental distress.

This conceptual introduction reviewed literature exploring patient and staff experience of restrictive practices in the acute inpatient mental health setting. The literature was gathered and assimilated from a variety of sources. This included a search utilising the database Web of Science, and additionally the inclusion of articles, books and policies relevant to the topic. This conceptual introduction provides a detailed introduction to the research topic, including an outline and definition of concepts central to understanding the experience of restrictive practices within the inpatient psychiatric setting, including the terms 'patient', 'distress', 'inpatient mental health care' and 'restrictive practices'. The review of literature identified themes central to the experience of restrictive practices including: the environment of the ward; coercion; coercion and the therapeutic alliance; risk management; and positive experiences. The implementation of restrictive practices was seen to continue to present a controversial issue within the practice of psychiatric care, as whilst the use of restrictive practices is seen in the literature to provide staff with methods for providing a safe environment and assessing and managing risk, accounts of restrictive practices persist in presenting negative experiences for both patients and staff.

The conceptual introduction presents identified gaps in the literature, including a need for more research exploring restrictive practices in the UK context. It also considers the various methodological approaches taken in the reviewed

studies. Finally, the conceptual introduction reflects on clinical implications and makes suggestions for further research.

Introduction

The empirical research study in this thesis (see Part 2) explored the contemporary lived experience of restrictive practices within an adult acute inpatient mental health hospital, from the perspectives of both patients and multidisciplinary staff members. Currently, there is an urgent drive within policy surrounding inpatient mental health care to reduce the use of restrictive practices (Care Quality Commission, 2017a) and national programmes aiming to reduce these practices are underway in the UK (Royal College of Psychiatrists, 2019). The experience of acute mental health care is documented in the literature as being at times traumatic (Morrison, Bowe, Larkin, & Nothard, 1999), being characterised by difficulties forming relationships with staff (Gilburt, Rose, & Slade, 2008), where practices are experienced as coercive (Meehan, Vermeer, & Windsor, 2000),and the setting is experienced as unsafe by both patients and staff (Wood & Pistrang, 2004).

Literature has explored patient and staff experience of inpatient mental health care, however qualitative research that examines experiences of restrictive practices in the UK care setting is currently lacking (Mellow, Tickle, & Rennoldson, 2017; Spinzy, Maree, Segev, & Cohen-Rappaport, 2018; Wilson, 2018). Further research in this area is necessary under the present focus on developing care practices and reducing the use of restrictive interventions. The empirical study (Part 2) intended to address this gap by undertaking a qualitative exploration of patient and staff member experiences of restrictive practices. Adopting ethnographic methods enabled a detailed exploration of the lived experience of restrictive practices in this setting. The

findings from the study are intended to inform further developments and support the implementation of restrictive practice reduction programmes.

This conceptual introduction reviewed literature relevant to the study. The method of the review began by utilising the database Web of Science. An iterative approach was adopted, whereby the researcher moved back and forth between the literature and the concepts and themes as they emerged during the review and became significant to the topic being explored. The prevalence and significance of particular terms occurring in the literature informed the terms that came to be selected for inclusion in the conceptual introduction. The chosen terms were also discussed within supervision and checked for their relevance. Some concepts identified in the literature were not included in the introduction as they were deemed not to be relevant, for example studies focusing on the use of mechanical restraint, which is not an approach used in the UK (Steinert et al., 2010). The review of the literature identified a long standing debate surrounding inpatient mental health care generally, and the use of restrictive practices specifically. Therefore it was deemed appropriate to include a brief overview of some of the key historical debates relevant to the setting and topic under review. Reference lists of identified documents and articles were also utilised to source further relevant documents. The search was also guided by knowledge of the supervisors, particularly in relation to relevant policy documents. Some areas that seemed less directly relevant to the study were excluded from the review. This again was informed by taking an iterative approach and through utilising discussion in supervision. The benefit of undertaking this conceptual review of the literature was the ability to include a broad range of literature documents, including research literature as well as policy documents. The

limitation however of adopting this approach rather than a more systematic review of the literature may have been a lack of depth.

The delivery of acute mental health care is informed by multiple disciplines including psychiatry, clinical psychology, mental health nursing and occupational therapy. Defining key concepts central to the empirical study is particularly important when conducting research in the context of a multidisciplinary setting, where various disciplines may construct the concepts differently, from varying perspectives. The conceptual introduction begins by providing a reflection on the term 'patient' and the term 'distress'. It will then outline key concepts relevant to the study including 'inpatient care' and 'restrictive practices'. These key concepts were identified from the search of the literature in the area of experiences of restrictive practices in the inpatient setting. It also provides a background to the setting of inpatient acute mental health care and the context within which the study was undertaken.

The conceptual introduction then reviews literature specifically exploring experiences of restrictive practices. The search of the literature exploring the experience of restrictive practices highlighted findings across key areas including: the ward environment; coercion; coercion and the therapeutic relationship; risk management; and positive experiences. An overview of the literature within these areas will be explored below. Finally, the conceptual introduction provides a rationale for the chosen methodological approach adopted in the study.

Method of literature review

A search of the literature was undertaken. This included a combination of a search of historical and contemporary empirical and theoretical articles and books as

well as a search of the literature utilising the database Web of Science. Policies from the United Kingdom (UK) related to inpatient mental health care focusing on restrictive practices were also reviewed. The search undertaken on the database Web of Science (2nd January 2019) initially identified 356 articles. Search terms can be found in Appendix 1. Article titles were scanned for relevance and abstracts read for further clarification. Duplications and articles that were deemed not relevant to the study were removed. This resulted in 103 articles being identified. Hand searching of reference lists was also undertaken to identify other key literature not included in the initial search of the database.

Exploration and definition of concepts

The search of the literature highlighted terms that are key to providing an understanding of the topic under review. Firstly, definitions of terms including 'patient' and 'distress' are outlined. This is due to the multiple ways in which individuals who access the service are referred to and the various ways in which their experiences of mental health difficulties are described within the literature from the perspective of different disciplines. An overview of the role and function of inpatient mental health care is then given to provide the context of this review and of the empirical study. Within this overview, a definition of restrictive practices is provided, with an outline of how restrictive practices are currently considered within policy. Finally, a critical review of the nature of inpatient psychiatric care is given to introduce some of the controversies that have been present within this setting over time and which may link to or inform the current experience of restrictive practices in the inpatient mental health setting. This includes a reflection on inequality of access and treatment experienced by Black and minority ethnic (BME) communities

and it also reviews accounts of patient and staff experiences of care, including a focus on the role of power within psychiatric care in relation to compulsory treatment and coercive practices.

Individuals who access inpatient psychiatric care

Numerous terms are currently used to describe individuals who access mental health services. The specific terminology adopted has implications for the construction of the meaning attached to the term (Speed, 2006). An outline of the commonly used terms is given here, leading to a rationale for the adopted term for this thesis.

Little consensus exists as to which term is preferred to refer to individuals accessing mental health services. Whilst it is noted in the literature and whilst medical bodies may have a dominant preferred term, multiple terms are often seen to be utilised within one document (Simmons, Hawley, Gale, & Sivakumaran, 2010). Different terms are used between various disciplines, with the Royal College of Psychiatry opting most regularly for 'patient', the British Psychological Society using 'client', and Mind adopting 'user', 'service user' or 'user/survivor' (Simmons et al., 2010). Studies exploring individuals' favoured terms note a preference for 'patient' (Ritchie, Hayes, & Ames, 2000) and some differentiate between favoured terms when being addressed by different professionals, with 'patient' being preferred when used by psychiatrists but no significant difference between 'patient' or 'client' when used by community mental health nurses, psychologists, occupational therapists or social workers (McGuire-Snieckus, McCabe, & Priebe, 2003; Simmons et al., 2010).

A discourse analysis of terms including ‘patient’; ‘consumer’ and ‘survivor’, concludes that each term constructs a different understanding of what it means to be an individual accessing mental health services (Speed, 2006). The term ‘patient’ is seen to indicate a passive acceptance of a diagnosis and an active role in seeking treatment. ‘Consumers’ draws from anti-psychiatry in which the individual moves between acceptance and rejection of the patient discourse, and ‘survivor’ is said to arise out of a rejection of the sick role and of a medical explanation for their distress (Speed, 2006).

Thus the term that is adopted can have implications for the meaning attached to the term. This highlights the need to carefully consider the choice of terms utilised. The preferred term may vary from individual to individual and preferences may change over time, suggesting there is no one right term (Cromby, Harper, & Reavey, 2013). As this study was undertaken in the medical setting of the acute inpatient ward, where interaction with staff such as psychiatrists and nurses is common, it followed other research undertaken in similar settings (e.g. Reavey, Brown, Kanyeredzi, McGrath, & Tucker, 2019) and the term ‘patient’ was adopted, as it has been noted that individuals have a preference for this term when being addressed by psychiatrists and nurses (McGuire-Snieckus et al., 2003). Additionally, the term ‘client’ suggests that the individual has chosen to make use of a service on offer. As some individuals are detained against their will in the inpatient setting, it was felt that the term ‘patient’ was more appropriate than ‘client’ in the context for this study.

‘Distress’

Various terms are also used when discussing the experiences of individuals accessing mental health assessment and treatment. The terms ‘mental illness’ and

'psychopathology' often used within psychiatry conceptualise these types of experiences as an illness in relation to health and sickness and as grounded within a biological framework (Cromby et al., 2013). An alternative term of 'distress' is used to refer to the same concepts as outlined in the Diagnostic and Statistical Manual of the American Psychiatric Association (American Psychiatric Association, 2013), but does not frame these experiences within a biomedical model, presenting the view that these experiences are not driven by disease or sickness (Cromby et al., 2013). The term 'distress' will be used throughout to emphasise that the model of understanding of distress adopted is not limited solely to the biomedical model due to the multidisciplinary approach present on the ward, including psychiatry, nursing, clinical psychology and occupational therapy.

Acute inpatient psychiatric care provision

Various terms are used to describe the provision of care in this inpatient setting including 'acute psychiatric care' (Crisp, Smith, & Nicholson, 2016) and 'acute mental health care' (Care Quality Commission, 2017b). Due to the multidisciplinary delivery of care, this thesis adopted the term 'acute mental health care'.

Acute mental health care is a longstanding and well-established form of health care that supports some of the most vulnerable and distressed individuals in society. For many people experiencing acute mental distress, prompt admission to inpatient care is vital and inpatient care continues to be seen as a crucial and valuable intervention (Mind, 2011).

The Royal College of Psychiatrists describe the role of acute inpatient mental health care as being:

> "to provide treatment when a person's illness cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible" (Crisp et al., 2016, p. 16).

A multidisciplinary approach to care is provided in this setting, with input from psychiatry, mental health nursing, clinical psychology, occupational therapy and pharmacology. Guidelines detail the amount and type of interventions to be provided in the inpatient setting, which includes access to a qualified psychologist (Perry, Palmer, Thompson, Worrall, & Chaplin, 2017).

As a result of the deinstitutionalisation of acute mental health care over the past sixty years, a shift has moved from an emphasis on long stay inpatient care to a preference for delivering care within the community where possible. This has contributed to a reduction in the number of beds available (Garcia, Kennett, Quraishi, & Durcan, 2005) and a subsequent increase in the complexity of the needs of patients being admitted (Deacon, Warne, & McAndrew, 2006; Quirk & Lelliott, 2001). One of the key driving factors for this increased focus on community-based care was in part due to reports of abuse taking place and an aim to reduce the prevalence of compulsory treatment (Cromby et al., 2013). However, in recent years, reports of abuse taking place within inpatient settings have continued to be made, for example as documented at Whorlton Hall (Plomin, 2019) and the Winterbourne View Hospital investigation, which led to the introduction of the Transforming Care agenda (Department of Health, 2012).

Inpatient mental health care is implemented either under detention of a section of the Mental Health Act (2007), whereby the individual is not required to give their consent, or on a 'voluntary' basis, whereby the patient makes the decision themselves to be admitted to the hospital. Whilst there has been an ongoing rise in the number of admissions made under sections of the Mental Health Act as a result of multiple factors including increasing strain on services (Care Quality Commission, 2018), a review of the Mental Health Act brings to focus the aim to reduce involuntary admission to a point where voluntary admission becomes the norm (Department of Health and Social Care, 2018).

Restrictive practices within inpatient psychiatric care

Providing a safe environment and managing 'dangerousness' are identified as some of the key aims of inpatient mental health care (Bowers, 2005, p.231). A Department of Health guide for services seeking to minimise the use of restrictive practices asserts that restrictive practices aim to keep both patients and staff safe through the effective management of behaviour that is identified as challenging by staff (Skills for Care and Skills for Health, 2014). Restrictive practices have been defined in this document as interventions that make "someone do something they don't want to do or stopping someone doing something they want to do" (Skills for Care and Skills for Health, 2014, p. 9). Restrictive interventions aim to reduce danger to an individual or others through restricting a person's movement, freedom or liberty, for as minimal time as possible (Department of Health, 2014). Restrictive practices are delivered in a variety of ways, which can include: physical restraints; mechanical restraints (using devices); chemical restraints through the use of medication such as rapid tranquilisation; and seclusion. They may also include

blanket restrictions such as being kept on a ward with locked doors or experiencing limited and prohibited access to outdoor space (Department of Health, 2014). Restrictive practices also include regulations surrounding everyday activities, such as access to items such as mobile phone chargers and structured visiting hours. The implementation of restrictive practices are seen to vary widely across hospitals and wards both in terms of frequency and type of practice used (Mind, 2013).

Legislation such as the Mental Health Act (Department of Health, 2007) and the Mental Capacity Act (2005) outlines that care should always implement the 'least restrictive option' (Department for Constitutional Affairs, 2007), whereby restrictive practices should be a last resort (Skills for Care and Skills for Health, 2014). This highlights the need to consider alternative interventions first. Renewed focus has been given to the development of alternative strategies to manage behaviour that challenges, as outlined in recent government policies (Care Quality Commission, 2017a; Department of Health, 2014; NHS Protect, 2013; Skills for Care and Skills for Health, 2014). Initiatives aimed specifically at reducing the use of restrictive practices on mental health wards have also been developed, for example the 'Reducing Restrictive Practice Improvement Collaborative' (Royal College of Psychiatrists, 2019) in addition to best practice guidelines such as those provided by the Care Quality Commission (Care Quality Commission, 2017a) and the introduction of interventions such as Positive Behaviour Support (PBS) plans (Care Quality Commission, 2017a). PBS focuses on developing a functional understanding of the behaviours deemed to be challenging, in attempt to identify alternative support strategies to reduce these behaviours (LaVigna & Willis, 2012). PBS plans explicitly avoid the use of punishments, instead focusing on individualised positive behavioural strategies and are increasingly being utilised in the inpatient acute

mental health setting (Hamlett, Carr, & Hillbrand, 2016; Perry et al., 2017), as it is seen to support the reduced use of restrictive practices (LaVigna & Willis, 2012). These alternative approaches are informing the debate surrounding the use and minimisation of restrictive practices.

The need to reduce the use of restrictive practices is also detailed in the government review into the appropriateness of the Mental Health Act, which made recommendations for changes with the aim of improving the rights and dignity of individuals who receive treatment under a section of the Mental Health Act (Department of Health and Social Care, 2018). This was positively received by some mental health organisations (e.g. Mind, 2018). The UK government also recently published legislation regarding the use of force within mental health care settings. The Use of Force Act (2018) details the requirement for the specialised role of an individual within an NHS Trust or organisation delivering mental health care to oversee the use of force. This includes the need to publish practice guidelines, ensure all staff receive adequate ongoing training, and ensuring effective reporting and investigations of incidences where force is used. A focus on the use of force and of restrictive practices are therefore currently in the foreground of UK mental health care policy.

Critical review of inpatient mental health care

Inpatient mental health care has received critical appraisal across a range of sources over time including from research exploring patient and staff experiences from the perspectives of the multiple disciplines involved in delivering care, such as psychiatry, nursing and clinical psychology, as well as from within critical psychology and critical psychiatry positions. A review of some key areas of critique

focused on both the micro and macro level is presented here to provide a context to some of the issues faced within the setting of inpatient mental health care.

Inequality of access

A disproportionate number of individuals from BME communities are admitted to inpatient mental health care under a section of the Mental Health Act. More than four times the number of individuals from the BME community were admitted between 2017 to 2018 than those from White ethnic backgrounds (NHS Digital, 2018). Individuals from BME communities are more likely to be: over-represented within inpatient psychiatric care (Bhui et al., 2003); treated under compulsory detention of the Mental Health Act; experience coercion; be transferred to locked wards from open wards; and be referred less frequently for psychotherapy (Department of Health and Social Care, 2018; Fernando, 2011; Rogers & Pilgrim, 2010). There has been slow progress in addressing the inequalities experienced in mental health care (Mind, 2013) and improving care for members of the BME community continues to be highlighted as a priority within policy, for example as targeted in the recent review of the Mental Health Act (Department of Health and Social Care, 2018).

Negative accounts of the experience of inpatient care

In addition to the adverse experiences and the identified need to improve services for the BME community, the literature search also identified an overall need to improve care for all members of the inpatient mental health ward. Despite acknowledging many positive attributes within the provision of adult acute mental health care, the Royal College of Psychiatrists' independent commission concluded

that aspects of current provision were “inadequate” and even “potentially dangerous” (Crisp et al., 2016, p.6). Inpatient care persistently receives critical appraisal from both patients and staff, where central concerns relate to issues of coercion, feeling unsafe, difficulties building positive relationships with staff, and inadequate access to activities (Care Quality Commission, 2009; Crisp, Smith & Nicholson, 2016; Donner, Mutter & Scior, 2010; Glasby & Lester, 2005; Jones et al., 2010; Mind, 2011; Quirk & Lelliott, 2001; Quirk, Lelliott, & Seale, 2004; Walsh & Boyle, 2009; Wood & Pistrang, 2004).

Compulsory care, restrictive practices and power

The use of compulsory care, restrictive practices and coercion presents an imbalance of power in this setting, and issues related to power have fuelled debate surrounding inpatient care both at the level of individual experience and also at the level of collective, social experience. Numerous concerns relating to the human rights of individuals subjected to restrictive practices have been raised (Mann-Poll et al., 2018) and these practices have come under increased scrutiny in recent years (Care Quality Commission, 2017b), in part due to cases documenting extreme abuse taking place (Department of Health, 2012). As noted above, within the literature a focus is placed upon the use of coercive and restrictive practices and policies have been introduced to support the reduction of these practices with the aim of enhancing care (Bowers, 2014; Royal College of Psychiatrists, 2019).

The delivery of compulsory care enforced by the state on individuals, for example through detaining patients under sections of the Mental Health Act, and through the use of coercive and restrictive practices, has contributed to discussion and debate about the politicised nature of the experience and treatment of distress.

Foucault (1977; 2008) closely examined the role of power within the enclosure of the 'asylum' throughout history, whereby a 'psychiatric gaze' is placed upon patients as a tool of governmentality, which within a disciplinary society serves to promote a particular normality that is shaped by those in positions of power (Newnes, 2011). This tracing of the development of the asylum illustrates that the concept of 'madness' functions to separate out reason from unreason and supports the endorsement of those in positions of power within society (Rogers & Pilgrim, 2010). Mental health care is analysed as being enmeshed with the social and political aims of those in positions of power, whereby psychiatry is considered by some to be a biopolitical science due to its contribution to managing society, for example through implementing risk assessment and risk management and through linking mental distress to economic burden (N. Rose, 1996, 2018). A critique of the discipline of psychiatry and of the asylum model of inpatient care was made from within the discipline itself by psychiatrists and theorists such as Laing (1960) and Szasz (1972, 1994), who questioned the biological explanation and validity of the term 'mental illness' and critiqued the role of compulsory psychiatry in relation to an imbalance of power within capitalist society (Roberts & Itten, 2006).

Contemporary readings of the treatment of distress continue to consider the role of power and make links to features of neoliberal capitalism, whereby everyday life has become pathologised and viewed of as something that requires special management and control (Illouz, 2007). The neoliberal quest for individualism, personal responsibility and self-management is argued to lead to a sense of 'responsibilisation', whereby an individual becomes positioned as holding responsibility for reducing their experience of distress through making personal adaptations, rather than through targeting social injustice (Smail, 2005). This is

argued to maintain the status of those in positions of power through concealing the operation of power itself (Boyle, 2011). Movements within the discipline of psychology, such as Community Psychology assert that experiences of distress can only be understood within the social context (Orford, 2008) and organisations such as Psychologists for Social Change (PSC) actively consider the role of social structures and oppressive politics in the experience of distress, for example by highlighting the link between austerity politics and experiences of distress (McGrath, Walker, & Jones, 2016).

Throughout history, and continuing today, there is an active consideration of the role of power and the socio-political context within which mental health care is delivered and experienced. The social, cultural, political and economic context is linked to the function and experience of mental health care. A current understanding of the experience of the treatment of distress therefore may be further illuminated by a consideration of the socio-political context within which that experience is situated.

Literature exploring experiences of restrictive practices

Key areas related to the experience of restrictive practices in the inpatient mental health setting were identified during the literature search and will be outlined here. It begins by examining the nature of the ward environment as a whole, before examining experiences of care on the ward. Literature is reviewed that explores aversive experiences of inpatient mental health care, including a focus on the experience of physical restraint and seclusion, involuntary admission and trauma symptoms and experiences of coercive practices. Following this, a review of literature that discusses the role of risk assessment and risk management in relation

to experiences of care is outlined. Finally, an account of positive experiences of care in this setting is given.

The ward environment

Ethnographic explorations of the experience of mental health care offer accounts of the overall nature of the setting and how the setting may impact on patient experience. A key contribution to the literature exploring the experience of psychiatric care was made by Goffman (1961), whose seminal work, 'Asylum' ethnographically explored this setting and continues to be recognised as an influential text today (Suibhne, 2011). Asylum (Goffman, 1961) utilises an ethnographic method of participant observation over an extended period of time. From this detailed study, Goffman describes the asylum as a 'total institution', being characterised by having complete control over the patient (Cromby et al., 2013). Goffman's account of the experience of ward life as 'totalising' was documented as involving dehumanising experiences for patients (Suibhne, 2011). Goffman (1961) spoke of the loss of identity experienced by patients whereby individuals become "stripped of almost everything" (p. 130) and where the practices of restrictive interventions, such as the prevention of free movement, was analysed by Goffman as being experienced as potentially "mortifying" for the patients (Goffman, 1961, p. 137). Thus restrictive practices featured as contributing to a distressing experience of care in this 'total' environment.

More recent ethnographic explorations of ward life similarly utilised participant observation in addition to participant interviews. Here, the 'total institution' as presented in Goffman's (1961) analysis, is argued to still be a valid and useful metaphor for understanding the nature of the ward setting, but is seen to

now be additionally characterised by increasing features of permeability (Quirk, Lelliott, & Seale, 2006). Key factors illustrating this permeability between the ward and outside life are a tendency for short stays, a rapid turnover of staff and a continual maintenance of contact with the outside world during the inpatient stay (Quirk et al., 2006). Permeability is similarly identified in a further study utilising ethnographic methods including fieldwork observations combined with interviews with patients and staff within an inpatient medium secure forensic unit, where the practices of the ward were analysed as serving to position life after discharge from the ward as simultaneously close and far away (Tucker, Brown, Kanyeredzi, McGrath, & Reavey, 2018).

These studies adopting ethnographic methods examine the overall setting of the ward, reflecting on how particular practices undertaken on the ward may shape experience. The ward atmosphere has also received attention in the literature as being a key factor in the experience and outcome of care in inpatient mental health settings (Brunt & Rask, 2007). Within the literature reviewed, references were made to the atmosphere or the felt sense of the ward environment. Some literature exploring the ward environment used quantitative methods such as utilising the Ward Atmosphere Scale (WAS) (Moos, 1996) whilst qualitative methods examining this particular aspect of mental health care are less prevalent in the literature (Brunt & Rask, 2007).

It has been recognised that patients and staff are likely to have differing perceptions of the ward atmosphere, in part due to their reasons for spending time on the ward being very different (Schjødt, Middelboe, Lykke Mortensen, & Gjerris, 2010). Schjodt et al (2010) utilised the WAS, administering this with both patients and staff on a mental health ward. They concluded that overall there are similarities

between patient and staff 'ideals' for the ward, although some nuances between these accounts are noted, particularly in relation to patients diverging from existing recommendations in the literature regarding preferred levels of autonomy and control held by staff (Schjødt et al., 2010). A further study identified differences between patient and staff experience of what contributes to a positive ward atmosphere through the administration of the WAS, whereby the ward atmosphere is seen to be more important for patient satisfaction than for staff satisfaction (Rossberg & Friis, 2004).

Aversive experiences of restrictive practices

Negative outcomes and experiences were documented in the literature as occurring on the ward as a result of experiencing restrictive practices.

Physical restraint

Physical restraint as one form of restrictive practice was heavily focused on within the literature reviewed and thus a focus is given to this here. Physical restraint was linked to negative, harmful consequences for patients subjected to these practices. Physical restraint has been described as an 'extreme' way to manage a person's behaviour when they are distressed (Mind, 2013) and can be a dangerous practice (Lewis, Taylor, & Parks, 2009). The use of physical restraint in the UK can be experienced as humiliating, causing distress and in severe cases has led to injury and death, with 13 restraint-related deaths occurring in the UK between 1998 and 2013 (Mind, 2013).

A key article by Cusack and colleagues (2018) provides a recent review of literature exploring the experience of physical restraint within inpatient mental health

settings. Across 10 studies they identified eight themes including: Trauma/re-traumatisation; Distress; Fear; Feeling ignored; Control; Power; Calm; and Dehumanising conditions (Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018). This recent review included articles published since 2000 and it highlights serious concerns regarding the potentially negative impact of the restrictive practice of physical restraint for patients and staff. This review echoes a previous article, which similarly reviewed experiences of physical restraint. It identified themes including: negative psychological impact; re-traumatisation; perceptions of unethical practices; and the broken spirit (Strout, 2010). Negative consequences of physical restraint including both physical and psychological harm have been identified throughout the literature (Cusack et al., 2018; D. Rose, Perry, Rae, & Good, 2017), and the practices themselves are argued to cause iatrogenic harm (Mellow et al., 2017). This has led some to argue for the cessation of the legitimisation of these practices, for example through endorsement in being included in government policies outlining care (D. Rose et al., 2017).

Although some literature exists, further research is required to understand the physical and psychological impact of physical restraint in the inpatient psychiatric setting (Cusack et al., 2018; Spinzy et al., 2018; Wilson, 2018), in order to meet the needs of patients more effectively and to improve services (Cusack et al., 2018).

Seclusion

Echoing Goffman's (1961) analysis that care within the inpatient setting can encompass dehumanising practices, further studies document the dehumanising impact of the practice of seclusion, whereby patients become ‘objects’ (D. Holmes, Murray, & Knack, 2015). The experience of seclusion or restraint is likened to a

sense of being imprisoned (Goulet & Larue, 2018), where the environment of the ward encompassing locked doors and high fences is experienced as replicating key features of the prison setting, reinforcing the lived experience of being locked up as though in prison (Kanyeredzi, Brown, McGrath, Reavey, & Tucker, 2019). Similarly to literature exploring experiences of physical restraint, further research is required to examine the impact and experience of seclusion in the inpatient mental health setting as existing research is limited and of varying levels of quality (Mellow et al., 2017). Further research would contribute to developing an evidence base for policies and best practice guidance, as well as building a better theoretical understanding of the processes involved in the experience of seclusion (Mellow et al., 2017).

Coercion

Being subjected to restrictive practices has been linked to feelings of coercion, powerlessness and a lack of perceived control (Meehan et al, 2000), and can impede recovery through re-traumatisation (Cusack et al., 2018). Coercive acts are actions that may be brought about through compulsion, force or through the implementation of authority. Coercion is defined as occurring when an act is subjectively perceived by an individual to be coercive (Newton-Howes & Mullen, 2011). Subjective individual experiences of coercion may differ to the perceived coercion of more overtly observable coercive acts (Hoge et al., 1993). Thus an action that is compulsorily made upon an individual, may not always be perceived by that individual as coercive (Newton-Howes, 2010) and an action that is not deemed to be coercive by the person implementing the action, may be perceived as coercive by the recipient.

Being repeatedly subjected to coercive practices negatively impacts on the individual's sense of self by leading to the erosion of self-confidence and trust in the individual's own thoughts and feelings (Ling, Cleverley, & Perivolaris, 2015), as well as a loss of autonomy (Spinzy et al., 2018) and can be viewed by patients as an attack on their skills in self-regulation (Katsakou & Priebe, 2007). Coercive practices can result in individuals feeling humiliated (Nyttingnes, Ruud, & Rugkåsa, 2016) and can have a significant negative impact on patient levels of satisfaction with care (Woodward, Berry, & Bucci, 2017).

Restrictive practices inherently have the potential to be perceived as coercive, as the techniques involve forcing someone to do something they do not want to do, or preventing them from doing something they wish to do. Practices that are perceived as coercive are unavoidably associated with an experience of control. A lack of ability to control important experiences has been directly linked to the occurrence of psychological distress (Powers, 1992) across a range of mental health difficulties (Carey, 2008). Thus experiencing a lack of control within the mental health setting may have an impact on the distress experienced by the individual.

Whilst restrictive practices such as restraint and seclusion may be more overtly coercive, less overtly coercive practices are also experienced as coercive by patients, such as the use of 'time out' and medication requested 'as needed', known as 'pro re nata' (PRN) (Kanyeredzi et al., 2019). This further illustrates that coercive acts are determined as such by the individual involved. In exploring subjective experience of restrictive practices, it is necessary to be led by the individual's experience about what they deem to be coercive or restrictive, rather than including only the practices that are more overtly coercive, as coercion can only be perceived by the person experiencing it (Newton-Howes, 2010).

Coercion and the therapeutic alliance

Coercive practices were also identified as playing a role in affecting the relationship between patients and staff. Negative consequences for the alliance were identified (Knowles, Hearne, & Smith, 2015), whereby a higher level of perceived coercion was seen to predict poorer therapeutic alliance (Gilburt et al., 2008; Theodoridou, Schlatter, Ajdacic, & Ager, 2012). The use of restrictive practices leading to experiences of coercion and a lack of perceived control may present a barrier to developing a therapeutic alliance (Gumley, Braehler, Laithwaite, Macbeth, & Gilbert, 2010). This is pertinent as the therapeutic alliance within the ward setting is identified as being a key factor both in helping to create a perception of the ward as being a safe place (Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013) and in affecting the outcome of the treatment of mental distress (Gallop, Kennedy, & Stern, 1994; McCabe & Priebe, 2004).

Whereas for patients restrictive practices are identified as severing trust and negatively impacting on the therapeutic alliance, this stance is not shared by all staff (Goulet & Larue, 2018). This lack of shared experience could hinder the development of a positive therapeutic alliance between patients and staff following a restrictive intervention. It may also present a challenge in developing a shared understanding of coercion between patients and staff, due to being perceived differently by different people (Larsen & Terkelsen, 2014; Lorem, Hem, & Molewijk, 2014; D. Rose, Evans, Laker, & Wykes, 2015), which could impact on the delivery of care.

A high score on a measure of perceived coercion is associated with a poor therapeutic relationship, suggesting that a positive therapeutic alliance may support the reduction of levels of perceived coercion (Sheehan & Burns, 2011). The quality

of the therapeutic alliance and the quality of interaction between patients and staff is also seen to mediate the ability for patients and staff to rebuild trust following restraint (Khatib, Ibrahim, & Roe, 2018). Effective communication is seen as vital in the implementation of restrictive practices (On Snorrason & All Biering, 2018). Numerous articles made a call for better training for staff to communicate more effectively with patients, and to be skilled in the use of debrief following restrictive practices (Brady et al., 2017; Chambers, Kantaris, Guise, & Välimäki, 2015; Lantta, Anttila, Kontio, Adams, & Välimäki, 2016; Seed, Fox, & Berry, 2016; van den Hooff & Goossensen, 2013).

Restrictive practices are not experienced as therapeutic (Ling et al., 2015) and the presence of restrictive practices on the ward can impact on staff members' abilities to provide therapeutic care, with the experience of forced treatment leading to patients and staff to identify conflicting goals for treatment (Wood, Williams, Billings, & Johnson, 2019). However, despite challenges in building therapeutic relationships under a context of forced detention, this is seen to be possible in the inpatient psychiatric setting (Small, Pistrang, Huddy, & Williams, 2018).

Involuntary admission and Post-traumatic stress disorder (PTSD)

The search of the literature also highlighted issues relating to the admission experience. The experience of being admitted to a psychiatric hospital is associated with symptoms of post-traumatic stress being experienced by patients (Morrison et al., 1999). Specifically for individuals experiencing symptoms of psychosis, involuntary admission to hospital has been correlated with symptoms of PTSD in the experience of a first episode of psychosis (McGorry et al., 1991). This is pertinent as 65% of beds within acute mental health care are occupied by individuals

experiencing symptoms of psychosis (Public Health England, 2016). However, there is little consensus in the literature as to whether factors specifically related to the admission itself, or factors related to the experience of the symptoms of psychosis are linked with post-traumatic symptoms upon admission (Mueser & Rosenberg, 2003). Other studies have found no link between psychiatric admission and symptoms of PTSD in the same population of individuals experiencing symptoms of psychosis (Beattie, Shannon, Kavanagh, & Mulholland, 2009; Meyer, Taiminen, Vuori, Äijälä, & Helenius, 1999). Thus inconsistent associations between hospital admission and PTSD in individuals experiencing symptoms of psychosis has been noted in the literature (Berry, Ford, Jellicoe-Jones, & Haddock, 2013). The presence of symptoms of psychosis and how these may impact on the experience of involuntary admission is complex (Seed et al., 2016) and further research is required to understand the prevalence and consequences of traumatic events that occur within the psychiatric hospital setting in order to contribute to the development of programmes that support staff in this setting to minimise the likelihood of patients experiencing further traumatic experiences on the ward (Frueh et al., 2000).

Risk management

A key role that restrictive practices were seen to play in the reviewed literature was that of being a tool for staff in maintaining safety on the ward. The management of risk in the inpatient mental health environment is described as forming the foundation of mental health nursing, driven by a central quest to maintain safety on the ward (Slemon, Jenkins, & Bungay, 2017). Slemon et al (2017) utilise a definition of risk outlined by Lupton (1999) as being the view that dangerous or adverse events are possible but can be preventable. Risk assessment in

the mental health setting has been outlined by a report into the use of risk assessment measures as involving a consideration of social and psychological factors of a patient's care needs and to assess their risk of harming themselves or others (National Confidential Inquiry into Suicide and Safety in Mental Health, 2018). A summary of the concept of risk within mental health hospitals sees 'risk' within this setting as deviating from focusing on the risks arising from issues related to nursing practice, such as medication errors, as is emphasised within physical health hospital settings and instead locates the 'risk' within the individual patient (Slemon et al., 2017). The use of restrictive practices has been directly linked to goals of monitoring and controlling the risk perceived to be posed by patients (Chow & Priebe, 2013). Restrictive practices have been conceptualised as a way to manage behaviour that is perceived as challenging and that poses a risk either to the individual or to others (Muir-Cochrane, O'Kane, & Oster, 2018). Controlling for safety through managing risk appears to be a key feature of care as outlined within policy (Langan & Lindow, 2004), as well as forming a key motivator for staff in using restrictive practices in this setting (Muir-Cochrane, O'Kane, et al., 2018; Rogers & Pilgrim, 2010). Staff time has become saturated by risk management, which is argued to be to the detriment of delivering therapeutic interventions (McCrae, 1014; Rogers & Pilgrim, 2010; Sharac et al., 2010). This focus on risk management is also seen to flow into patient experience whereby inpatient care has been described by some as solely a strategy to contain risk (Nolan et al., 2011).

The decision to implement coercive interventions is often based on: contextual demands; lack of alternatives; the escalatory effects of restraint itself; and perceptions of risk (Perkins, Prosser, Riley, & Whittington, 2012). The unpredictable nature of the environment was also cited as a reason for the use of restrictive

practices (Perkins et al., 2012). It is identified that whilst some of these factors could be addressed through structural changes, nurses tend to view restraint as a 'necessary evil' (Wilson et al., 2017), as the need to control for a safe environment results in the implementation of restrictive practices as a last resort, despite the negative emotional and relational outcomes reported by both staff and patients (Slemon et al., 2017; Wilson et al., 2017) . Thus the experience of a lack of safety on the ward, as assessed by members of staff, is identified as a justification for the use of restrictive practices. Protecting patients' rights and avoiding abusive practices can lead staff to feel conflicted about using coercive interventions in order to maintain social order, whereby the rationalising of these practices serves as a coping strategy (Goulet & Larue, 2018). Thus a conflict is documented between the desire to provide respectful and empowering care, and that of the public expectation to ensure risk is effectively managed (Quirk et al., 2006). Strategies with the intention of upholding safety have been argued to be ineffective and cause harm to patients and yet are seen to persist in mental health care due to being legitimised by the dominant narrative surrounding the need to ensure a safe environment (Slemon et al., 2017).

The quest to manage risk therefore creates a complex negotiation for staff between delivering care that is experienced as therapeutic and effective, and in delivering strategies to manage risk (Curtis et al., 2013; Tucker et al., 2018). The endeavour to reduce restrictive practices may further exaggerate this tension between the commitment to ensuring patient-centred, quality practice and continuing to maintain a safe environment for all (Muir-Cochrane, O'Kane, & Oster, 2018; Wilson, Rouse, Rae, & Ray, 2017).

Benefits of restrictive practices

The aim of maintaining a safe environment through the implementation of restrictive practices was noted in the literature to be experienced positively by some patients (Kinner et al., 2019) and restrictive practices are discussed in terms of their value. For example, the presence of locked doors on the ward has been linked to a feeling of safety (Van der Merwe, Bowers, Jones, Simpson, & Haglund, 2009). A theme of 'calm' has also been identified in a recent review of articles exploring the experience of physical restraint in the inpatient mental health setting (Cusack et al., 2018). Thus the use of restrictive practices are not solely negatively criticised by those involved and the need to provide a safe environment for all on the ward is identified as a rationale for the use of these interventions. However, it is also clear that careful consideration needs to be given when implementing the practices, and the current focus on developing alternative methods and reducing the practices suggests that care will be enhanced when these practices have been reduced.

Summary

Based on the literature outlined above, the experience of restrictive practices for both patients and staff is identified as multifaceted and complex. The practices themselves are intricately linked with experiences of power and coercion and are seen to shape the way in which inpatient mental health care is experienced by individuals. Despite the extent of literature presenting negative consequences that restrictive practices can have for both patients and staff, the need to ensure a safe environment provides a strong rationale to those present on the ward as to the legitimate need for these practices (Slemon et al., 2017). However, the detrimental impact that restrictive practices are seen to have has contributed to a recent focus

within policy and mental health care to focus on introducing alternative methods to manage 'risk' in the setting and to reduce the use of restrictive practices where possible.

Further research is required to develop a clearer understanding of the current experience of restrictive practices, such as that of physical restraint (Cusack et al., 2018), in order to support the development of effective reduction programmes.

Discussion

Clinical implications

Implications for clinical practice identified in the literature are given here and are also considered in Part 2.

Communication between patients and staff in this setting was identified in the literature as being related to the experience of coercion and of restrictive practices. Poor communication during the implementation of a restrictive practice can have additional negative consequences for the patient directly involved, staff members and other ward members. Interventions that aid the development of effective communication between staff and service users may reduce these negative consequences (Brady et al., 2017; Chambers et al., 2015; Lantta et al., 2016; Seed et al., 2016; van den Hooff & Goossensen, 2013). Improving communication skills is identified therefore as a key area warranting further development in clinical practice across the multiple disciplines that provide care in this setting. Additionally, facilitating open discussions about the use of restrictive practices may foster increased insight into the impact these practices may have on members of the ward. Encouraging staff to adopt an attitude whereby all interventions are considered to

have the potential to be experienced as coercive by patients may also have a positive impact on the experience of care in this setting (Newton-Howes & Mullen, 2011).

The impact of perceived coercion on the experience of care and restrictive practices is highlighted in the literature as playing a key role. Staff can be influential in attempting to reduce the impact of perceived coercion by working to support patients to experience autonomy and participation in their treatment where possible as well as providing care which is experienced by patients as genuine (Katsakou & Priebe, 2007). Nurses are well placed to engage patients as active participants in their care (Cusack et al., 2018) and the implementation of programmes such as 'Safewards' (Bowers, 2014) are identified as being well placed to support these initiatives (Cusack et al., 2018).

Providing improved support for staff delivering restrictive practices may also improve experiences of care. Clinical implications noted in the literature involves the discipline of clinical psychology through the delivery of supervision and staff support, such as by facilitating reflective practice groups, which improve the quality of inpatient mental health care (J. Holmes, 2002). Clinical psychology has successfully introduced interventions aimed at improving inpatient care. For example, the introduction of team formulation meetings improves relationships between staff and service users, improves staff understanding of patients and supports collaborative working as well as helping to increase staff awareness of their own feelings (Berry et al., 2016). Clinical psychology within inpatient care contributes a psychological understanding to inform interventions and supports staff in maintaining a safe and therapeutic environment (British Psychological Society, 2012). The area of research exploring the transferability of psychological interventions to the inpatient ward environment is limited, but argued to be growing

(Clarke & Wilson, 2009; Reynolds, Desai, Zhou, Fornells-Ambrojo & Garden, 2016). A recent systematic review concluded that there is a growing evidence base for the effectiveness of clinical psychological interventions within the acute inpatient setting in reducing distressing symptoms and reducing rates of readmission (Paterson et al., 2018). This highlights the role that clinical psychology specifically could play in developing interventions that support the effective reduction and use of restrictive practices as needed.

A further clinical implication relates to the dynamic and changing nature of perceptions of treatment, which can vary over the time course of an admission (Seed et al., 2016). Thus it is imperative to continue to explore patients' experiences of care and of restrictive practices across the timespan of their admission, not just at particular points, such as admission or discharge.

Methodological approaches for exploring lived experience within health care settings

Epistemology

Few studies explicitly noted the epistemological stance taken in the research. A realist epistemology was adopted in one study, whereby participant responses were considered to represent reality, with the view taken that this reality will differ between that of patients and staff, leading the authors to distinguish in the study from which type of participant the data came from (Wilson, 2018). A critical realist approach was taken in another study (Wood et al., 2019). Building from social constructionism, critical realism, as introduced by Bhaskar (2010) views reality as multiple and as being shaped by the specific cultural and social situation in which it

is formed (Parker, 2002). It also asserts that data requires interpreting by the researchers to allow access to underlying structures that inform the shaping of the experience of reality (Willig, 2013).

Methodological approach

The majority of the studies reviewed utilised qualitative methodology, primarily undertaking a thematic analysis of semi-structured interviews. A few studies, such as those exploring the atmosphere of the ward utilised quantitative methods and employed questionnaires, such as the WAS to explore experience in the inpatient setting.

There is no one preferred method for collecting patient experience data (Coulter, Locock, Ziebland, & Calabrese, 2014). Quantitative methods, such as the 'Friends and Family' test whereby patients are asked in real time whether they would recommend the service they have experienced to other people are popular, however a small response reduces the ability to make generalisations from the data as intended. Quantitative measures are seen to lead to an increased number of positive responses than are identified within more in-depth qualitative questioning (Coulter et al., 2014; Perreault, Leichner, Sabourin, & Gendreau, 1993) and are less engaging to staff (Coulter et al., 2014). Clinical implications may thus be more likely to be successfully implemented where qualitative methods are used, due to being more effective in engaging staff. The use of open-ended questions within qualitative methods has the potential to allow the participant to identify their personal preoccupations regarding their experience of the health care service (Perreault et al., 1993) and qualitative approaches have been suggested to be suitable to exploring

patient experience within inpatient environments (Greenwood, Key, Burns, Bristow, & Sedgewick, 1999).

Ethnography has been identified as a valuable qualitative approach to research within the health care setting both generally (Savage, 2006), and also specifically within the inpatient mental health environment (Quirk & Lelliott, 2001). Key ethnographic projects outlined in this review presented detailed insight into lived experience of inpatient care (e.g. Goffman, 1961). Ethnographic practice is hard to define due to having numerous ways in which it can be implemented (O'Reilly, 2012). The ethnographic approach can incorporate a multitude of theoretical principles and methods, but is characterised by a primary focus of becoming immersed in the environment under study, gathering data from multiple perspectives and viewpoints (Savage, 2006). Ethnography thus draws on a wide range of different sources of information (Hammersley & Atkinson, 2007) and can include a programme of repeated and varied observations and data collection and observations of reactions to the observations (Miller, Hengst, & Wang, 2003).

The ethnographic observational method utilised in 'Asylum' (Goffman, 1961) is argued to be one of the study's enduring contributions (Adlam et al., 2012), suggesting that this approach continues to be relevant to studying the contemporary ward environment. The other ethnographic studies reviewed above combined the use of fieldwork observations with semi-structured interviews, which provided a duality of methods ensuring a rich and varied data set (Quirk et al., 2006; Reavey et al., 2019).

Conclusion

This conceptual introduction set out the background, context and key terms relevant to the literature exploring experiences of inpatient psychiatric care, with a focus on restrictive practices. The search of the literature illustrated that restrictive practices persist in being experienced and conceptualised as a controversial practice within mental health care. The literature above highlights the multifaceted ways in which these practices are deemed to impact on all members of mental health wards and a gap in the existing literature exploring the experience of restrictive practices in the UK settings has been highlighted (Wilson, 2018).

A fresh exploration of patient and staff experience in the contemporary mental health inpatient setting is warranted, given the current focus on the need to reduce the use of restrictive practices. Gaining insight into the lived experience of life on an inpatient mental health ward for people who use the services and also for the multidisciplinary staff team utilising qualitative methods will enable a reading of how restrictive practices are currently being experienced, and in how this may affect experiences of distress for both patients and staff. A call has been made for more ethnographic research to take place in this setting (Quirk & Lelliott, 2001). Studies adopting ethnographic methods are well placed to examine the multiple perspectives from the various stakeholders present on the ward. Further research could contribute to a growing understanding of the impact of the current policies introduced to reduce the use of restrictive practices. It may also contribute to enabling the multiple disciplines involved in delivering care including psychiatry, clinical psychology and nursing among other disciplines to develop further interventions and improvements in practice (Cusack et al., 2018).

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Part 2: Empirical Paper

An ethnographic study of psychiatric ward life: Exploring experiences of restrictive practices from the perspectives of patients and staff.

Abstract

Aims: This study aimed to explore the lived experience of restrictive practices in an inpatient mental health setting from the perspectives of patients and staff members.

Method: Qualitative ethnographic methods were used including semi-structured interviews, fieldwork observations and document analysis. The data was analysed using thematic analysis.

Results: Patients and staff conceptualised restrictive practices as methods to ensure safety. Both patients and staff described negative experiences related to restrictive practices. Patients experienced restrictive practices as part of a 'game', being implemented by staff through tactics and threats. Patients reported feeling dehumanised and responded to restrictive practices by surrendering to the needs of staff, or by breaking rules. Staff legitimised the practices through their inclusion in policies. Restrictive practices impacted on staff members' abilities to build a positive therapeutic alliance with patients and also had negative emotional consequences for staff. Staff responded to these experiences by utilising what they experienced to be more humane approaches, such as 'de-escalation' techniques. However, these 'de-escalation' techniques were experienced by some patients as coercive.

Conclusions: This study further validates existing findings in the literature that restrictive practices are viewed as being necessary to ensure safety, whilst simultaneously negatively impacting on the experience of care. This study highlights the different ways in which strategies to prevent the use of restrictive practices are experienced by patients and staff. Further research is required to gain a clearer understanding of the experience of practices aimed at reducing restrictive practices. There is also a necessity for co-produced programmes to be developed in order to support the reduction of restrictive practices.

Introduction

Inpatient mental health care is argued to be an essential form of care for individuals experiencing acute symptoms of mental distress. Inpatient care continues to provide support for some of the most vulnerable members of the community (Mind, 2011), with 49,551 new detentions under the Mental Health Act made in the United Kingdom (UK) between 2017-2018 (NHS Digital, 2018).

As highlighted in Chapter 1, care in this setting continues to attract criticism and debate. Literature persists in presenting negative experiences of care from the perspectives of patients and staff (e.g. Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018) and the inpatient setting is deemed to be at times an unsafe and untherapeutic space (Independent Mental Health Taskforce, 2015) for both patients (Wood & Pistrang, 2004) and staff (Mckinnon & Cross, 2008), with 33,820 reported physical assaults made against staff across 39 mental health trusts in the UK in 2016-2017 (Royal College of Nursing, 2018).

A current focus within policy is given to improving the quality of inpatient mental health care (Department of Health, 2012b). A recent review of the Mental Health Act has published recommendations for changes to the Act to focus on enhancing the dignity and rights of individuals admitted to hospital under a section of the Mental Health Act and makes a call for voluntary admission to become the norm (Department of Health and Social Care, 2018). Particular scrutiny within recent policies also focuses on the use of restrictive practices (Care Quality Commission, 2017b), whereby legislation outlines that care should entail only the 'least restrictive option' and restrictive practices should be utilised as a 'last resort' (Department for Constitutional Affairs, 2007; Department of Health and Social Care, 2018; Skills for Care and Skills for Health, 2014).

Restrictive practices are defined as interventions that make "someone do something they don't want to do or stopping someone doing something they want to do" (Skills for Care and Skills for Health, 2014, p. 9). Restrictive practices often result in a deprivation of an individual's liberty, with the intention to ensure a safe environment and reduce danger (Department of Health, 2014). The delivery of restrictive practices can take the form of seclusion, physical and chemical restraint (forced medication or rapid tranquilisation) and limited access to prohibited items (Department of Health, 2014).

Restrictive practices are often experienced to be coercive (Meehan, Vermeer, & Windsor, 2000), and can negatively impact on the experience of care, such as impeding recovery through re-traumatisation (Cusack et al., 2018) and damaging the therapeutic alliance (Gilburt, Rose, & Slade, 2008; Theodoridou, Schlatter, Ajdacic, & Ager, 2012). However despite these negative consequences, restrictive practices are also viewed as being essential in ensuring safety for both patients and staff in the inpatient setting (Cusack et al., 2018; Muir-Cochrane, O'Kane, & Oster, 2018). This leads to a complex negotiation for staff in delivering care that is person-centred and therapeutic, whilst simultaneously utilising strategies to manage risk.

Concern regarding the use of restrictive practices has led to the introduction of interventions focusing on the reduction of restrictive practices across the UK (Royal College of Psychiatrists, 2019; Wilson, Rouse, Rae, Jones, & Ray, 2015) from within the multiple disciplines providing care in this setting. Within the discipline of clinical psychology, interventions to support staff with this complex task have been made. A randomised control trial demonstrated benefits gained from an intervention delivered by clinical psychologists in the inpatient setting aimed at improving staff-patient relationships (Berry et al., 2017, 2016). This highlights the

role for clinical psychology to support the challenging task of providing care in this environment. Thus, whilst the implementation of restrictive practices in the ward setting is predominantly the responsibility of nursing staff, clinical psychology is well placed to utilise psychological theory and practice to support the multidisciplinary team in improving care and reducing the use of restrictive practices. For example, clinical psychologists can deliver training to staff informed by psychological theory, to improve collaborative working and the promotion of care that empowers and de-stigmatises patients, by bringing a psychological perspective to the patients' distress (British Psychological Society, 2012). The introduction of Positive Behavioural Support (PBS) is a further way that a psychological perspective in understanding distress can support the reduced use of restrictive practices (LaVigna & Willis, 2012). Training delivered by clinical psychologists may also promote a more therapeutic ward milieu, which can reduce the risk of violence (British Psychological Society, 2012). Additionally, reflective practice groups specifically focusing on the use of coercion have been seen to result in multiple positive benefits to ward staff, including developing skills to relate more effectively to patients (Olofsson, 2005). Delivering reflective practice groups is a key area of expertise for clinical psychologists and is a further way in which the discipline may contribute to improved experiences on the ward (British Psychological Society, 2012), both generally and in relation to the delivery of restrictive practices. Having a clear understanding of the experience of restrictive practices and coercion from the perspectives of both patients and staff is therefore relevant to supporting clinical psychologists to design and deliver effective interventions on the ward.

Key approaches to reduce restrictive practices are also utilised within the discipline of nursing, such as the improved use of strategies such as 'de-escalation'

methods. De-escalation strategies are complex (Stevenson, 1991), may involve 'non-pharmacological' or 'behavioural' strategies, and are implemented by multiple professionals on the ward, including nurses and therapists (Harwood, 2017). Training to improve the use of de-escalation methods is seen to be of benefit (Cowin et al., 2003). Nursing is also tasked with improving the overall care for individuals in the acute mental health setting, for example with reports guiding services on how to support improved access to physical health checks whilst accessing mental health services (Naylor et al., 2016; NHS England, 2016), as integrating physical and mental health leads to numerous benefits both for patients and for services (Naylor et al., 2016). Mental health inpatient staff report barriers to undertaking physical health checks as being a lack of time and the need to prioritise mental health (NHS England, 2016). Improving nursing confidence with undertaking physical health checks and providing additional training for inpatient nursing staff is suggested (NHS England, 2016).

A deeper understanding of the experience of restrictive practices would inform further developments to improve care. Whilst literature exists that explores patient and staff experience of inpatient psychiatric care, a gap has been noted in the literature exploring patient and staff experience of restrictive practices in the inpatient setting (Quirk & Lelliott, 2001), including a lack of research that explores patient and staff experience of restrictive practices specifically in the UK context (Wilson, 2018). Incorporating the patient perspective is increasingly recognised as essential in contributing to the evaluation and design of services through co-production (Crisp, Smith, & Nicholson, 2016; Department of Health, 2012a; Mind, 2011; Springham & Robert, 2015). Limited research exploring the experience of restrictive practices through an examination of any similarities and differences in the

accounts of restrictive practices as given by patients and staff, or the power dynamics between them is noted, and further research examining this interaction is needed (Rose, Perry, Rae, & Good, 2017).

Existing research predominantly focuses on exploring the experience of particular types of restrictive practices, most notably physical restraint (e.g. Cusack et al., 2018; Fish & Hatton, 2017; Perkins, Prosser, Riley, & Whittington, 2012; Wilson, 2018) and seclusion (Bowers et al., 2010; Mellow, Tickle, & Rennoldson, 2017). Lacking in the literature is an exploration of practices that are experienced as restrictive, as defined by the individuals themselves. Enabling participants to define for themselves the acts that they experience as restrictive allows for a broader exploration of the experience of restrictive practices and was deemed to be central to this study, as the experience of coercion is considered only to be definable by the person experiencing the act (Newton-Howes, 2010).

Research within health care settings is increasingly recognised as being effectively examined through the use of ethnographic approaches (Savage, 2006), and ethnographic methods are specifically noted to be suitable in facilitating an exploration of experience within an acute psychiatric inpatient setting (Quirk & Lelliott, 2001). Ethnographic approaches place a priority on gaining an insider's view of the group under study, which can be complex and at times contradictory (Griffin & Bengry-Howell, 2017). Ethnography aims to become embedded within the environment to provide a reading of the perspectives from multiple viewpoints, with attention particularly given to questions of power and inequality (Savage, 2006) and to the connections between people and social processes (Griffin & Bengry-Howell, 2017). This is particularly important in the present study whereby the aim was to gain an understanding of the experience of restrictive practices from the

perspectives of individuals who take up different positions and have differing levels of power in relation to the practices.

Research aims

There is an urgent need to understand how patients and staff experience contemporary inpatient mental health care within the current context of a national agenda to reduce the use of restrictive practices. This study aimed to contribute to the gap in literature by qualitatively exploring the experience of practices that are deemed to be restrictive from the perspectives of patients and staff.

Adopting multiple ethnographic methods allowed a detailed exploration of the setting within which restrictive practices are implemented. By incorporating the viewpoints of both service users and staff, a picture of the experience of care from the perspectives of multiple stakeholders was developed. The research aimed to build a triangulated understanding of restrictive practices by supplementing the interviews with fieldwork observations and an examination of relevant cultural artefacts relating to the experience of restrictive practices. This allowed for a multifaceted exploration of the experience of restrictive practices in the inpatient mental health setting.

Research questions

1. How do patients and staff members experience and make sense of restrictive practices?
2. How do patients and staff members respond to restrictive practices?

Method

Methodological Approach

The study adopted a qualitative, ethnographic methodology. Qualitative methods allow for a deep exploration of subjective experiences and are suitable and

appropriate for exploring patient experience within hospital environments (Greenwood, Key, Burns, Bristow & Sedgwick, 1999). Within psychology, qualitative research is concerned with the essence, quality and meaning of experience, rather than with discovering truths of phenomena (Willig, 2013). The study utilised semi-structured interviews, fieldwork observations and document analysis, allowing for a triangulation of the data, whereby the phenomenon is viewed from different angles (Willig, 2001).

Epistemology

This study sought to gain an understanding of how members of an acute mental health hospital made sense of the use of restrictive practices and of how they responded to these practices. A focus on gaining insight into the subjective experiences of the participants was a therefore a central aim of the study. These subjective experiences will be affected by the specific cultural, historical and socio-political climate of each individual and of the hospital.

A critical realist epistemology was adopted. Critical realism (Bhaskar, 2010) views reality as socially constructed and shaped by the cultural setting (Willig, 2012), but is additionally concerned with seeking to position the understanding of reality within enduring structures and mechanisms (Parker, 2002). Within a critical realist approach, data is required to undergo a process of interpretation, to allow access to the underlying structures involved in the generation of what is being studied, which is often not accessible to the participant (Willig, 2013). This allows for a contextualised exploration of the subject matter. As this project sought to build an understanding of the experience of restrictive practices as situated within a specific cultural and institutional climate, critical realism was adopted as the

epistemological stance. Alternative epistemological positions were considered for the study, such as a realist approach, however a realist approach does not allow for an interpretation of the data or consideration of the social context. As the use of restrictive practices are currently receiving attention within policy and the social context, it was felt that a critical realist approach would be more suitable.

Setting

The research took place on two adult acute wards, one male and one female, within a mental health hospital in a large city in the UK. The hospital has a total of 100 admission beds across a total of seven wards and the average length of stay at this hospital between 2017-2018 was 30 days. This was slightly below the average for this large city of 32.7 days.

A multidisciplinary team for each ward consisted of: Psychiatrists; Nurse Clinical Leads; Mental Health Nursing staff; Health Care Assistants; Occupational Therapist; pharmacy; Clinical Psychologist (two days per week per ward); Assistant Psychologist; and at times a Trainee Clinical Psychologist, if on placement from a local training course.

Ethical Approval

The study was approved by an NHS Ethics board (REF: 239990, see Appendix 2) and the local NHS Research and Development Team.

Sampling and recruitment

Convenience sampling was undertaken, whereby potential participants who met the inclusion criteria were included in the study in a first-come-first-served basis (Robinson, 2014). Purposive sampling was not used as the study was not specifically

targeting either certain disciplinary staff members, or patients with particular diagnoses or other distinguishable criteria.

The study recruited a total of nine patient participants and eight staff member participants, a total of 17 participants. Recruitment for the interviews ceased when the data was saturated. Within qualitative research, saturation is identified not through the number of participants or amount of data, but through consideration of the richness of the data (Carey, 1995) and of whether the data ceases to present new theoretical information or new themes (Tuckett, 2004). Transcribing and undertaking the analysis whilst continuing to facilitate interviews and fieldwork observations informed the ability to identify when saturation had been reached.

Patient Participants

Patient participants were recruited from two wards within the hospital, one male and one female ward. Both wards admitted patients of adult working age. At the time of recruitment, patient participants were currently admitted as an inpatient on either of the two wards. Patients continued to be eligible for the study if they were discharged from the ward following expressing an interest in taking part in the study. One participant was discharged and returned to the hospital site to take part in the interview. All other patient participants were admitted at the time of their interview. All participants were required to be deemed well enough by a member of the care team, including having capacity to consent to take part in the research. Exclusion criteria included the presence of a moderate to severe learning disability and inability to communicate in English to the level required to undertake an interview as funding for an interpreter was regretfully not available for the study.

Patients eligible for the study were initially approached by a member of the ward staff known to them. This was usually the ward psychologist or assistant psychologist. After being given information regarding the study, if the patient consented, they were then approached by the researcher. The researcher then provided further information about the study and answered any initial questions. The Information Sheet (Appendix 3) was provided at this time. This outlined the nature of the study and that their care on the ward would not be affected in any way if they decided to take part. Information about data protection and how the interview would be recorded and analysed was also provided. The patient was then given a minimum of 24 hours to decide whether they wanted to take part. If they agreed to take part, a mutually agreeable time was scheduled for the interview. A consent form (Appendix 4) was signed on the day of the interview, before the interview commenced.

Staff member participants

Staff member participants were, at the time of recruitment, current staff members of the same two wards. Staff members from all disciplines were invited to take part in the study. The job roles of the staff member participants included: Clinical Nurse Leads; Staff Mental Health Nurse; Health Care Assistant; Student Mental Health Nurse; Administrator; Support Worker; and Assistant Psychologist. Clinical Nurse Leads and Staff Mental Health Nurses would be expected to undertake restrictive practices, such as restraint as necessary, whereas other job roles including administrators, support workers, psychologists and assistant psychologists would not be expected to undertake practices such as restraint with patients. The staff member participants' interviews in this study therefore had varying roles in the delivery of restrictive practices.

Inclusion criteria included being able to communicate in English at the level required for the interview. Staff members were informed about the study through the ward manager directly and via an email written by the researcher and sent to staff email addresses by the ward manager. The researcher also attended a staff meeting and introduced the study. Potential participants were invited to speak with the researcher to express their interest in taking part. Those who were interested were then provided an Information Sheet with additional information (Appendix 5). The staff member was given a minimum of 24 hours to decide to take part. If the staff member wished to take part, a mutually convenient time for the interview was scheduled. Before the interview commenced, participants signed a consent form (Appendix 6).

Participant demographics

The patient participants were made up of five male patients and four female patients. Ages ranged from 22 to 58 and the ethnicities of the patient participants included Black British, White British, White Irish, Mixed British and British Pakistani. Every patient participant consented to disclose a mental health diagnosis they had been given and also disclosed their current length of stay on the ward and seven out of nine provided the number of admissions they had experienced in total (see Appendix 7 for demographic details).

The staff member participants were made up of one male and seven female staff members. The ages of the staff member participants ranged from 23 to 50. Length of time working on the ward ranged from six weeks to 10 years (see Appendix 8 for demographic details).

Design

This study utilised multiple ethnographic methods, which can provide an in-depth account and lead to a rich and varied data set (Miller, Hengst & Wang, 2003; Savage, 2006).

Semi-structured interviews

Individual semi-structured interviews were completed to gain detailed information directly from patients and staff. Two interview schedules were used for the semi-structured interviews, one each for patients (Appendix 9) and staff members (Appendix 10). During the design stages of the research, patient and public involvement was undertaken to inform the development of the interview schedules. Five members from the UCL Service User and Carer Forum reviewed early drafts of the interview schedule and information sheets and provided detailed feedback. This was invaluable in refining the research documents. The interview schedules guided the interviews, but still allowed for flexibility for the interview to be led by the participant. Both interview schedules began with an open, informal question, which aimed to put the participant at ease (Cruz & Higginbottom, 2013). The interviews explored the participants' experience of their time on the ward more generally, before asking open questions exploring the experience of care. Finally, questions asked more specifically about experiences involving restrictive practices.

Participants were given the option of attending a follow up interview, to allow for the participants to change their minds, correct details and provide new information (O'Reilly, 2012). No participants chose to attend a follow up interview. The interviews were audio recorded and transcribed verbatim (see Appendix 11 for transcription codes). Patient interviews took place in a small private room located on

the ward. Staff interviews predominantly took place in a small private room on the ward, but two were facilitated in a room on the hospital site off the ward. The interviews lasted between 25 and 80 minutes. Two staff member interviews were interrupted and were required to be re-started due to the room becoming unavailable, or the staff member being required to fulfil a duty. Many of the patient interviews were briefly interrupted at times by other patients or staff members entering the room.

Following completion of the interview, each participant was given a £15 voucher for a supermarket, located nearby to the ward.

Non-participatory overt observations

The researcher that facilitated the interviews undertook non-participatory overt fieldwork observations, whereby the researcher was present on the ward, but was not participating as a patient or member of staff. This consisted of visits to the wards by the researcher twice a week for a period of four weeks, for at least one hour on each day. The fieldwork took place on varying days of the week and at different times during the day and evening, to ensure a variety of activities and interactions were observed. The researcher was present in areas including the: TV room; activities room; corridors; dining room; nursing station; meeting rooms; and courtyard. Activities that were observed included: Community Meetings (attended by both patients and staff); ward rounds; meal times in the dining room; psychology groups; and staff 'Safety Huddles'. A significant period of time was also spent observing unstructured activities, such as time in the corridors and the TV room where patients often spent their time. Time was also spent in the nursing station,

where nursing staff often carried out administrative tasks and where patient items such as mobile phones were kept and charged.

The researcher wore a name badge clearly presenting her name and role of researcher, to distinguish herself from members of staff and from patients. Only participants who had consented to the study were included in the observations. All participants consented to the fieldwork component of the study.

Where possible, observations focused on events involving instances where restrictive practices were implemented. During the fieldwork, informal conversations would often take place where the participants spontaneously discussed their experiences (Cleary, 2003). The fieldwork helped to clarify findings from the interviews by presenting an opportunity to explore the context of the findings and examine concordance and discrepancies with the results gathered from the interviews (Fetterman, 1989).

As well as making mental notes during the fieldwork, a small notebook was used to note down brief key details. A separate diary was also used to log thoughts and reflections on the research process to guide the analysis and reflexivity by helping the researcher to 'stand back' from the research (O'Reilly, 2012).

Document Analysis

During the fieldwork, two cultural artefacts were identified that were considered relevant to the study. Reviewing relevant documents can be used to confirm or contradict the findings gathered from the interviews and observations (Cruz & Higginbottom, 2013). One poster from each ward was identified by the researcher during the fieldwork as being relevant to the study. Other documents that may have been beneficial to include in the document analysis included incident

reports documenting the implementation of restrictive practices, patient complaints and both local NHS Trust and national policies regarding the use of restrictive practices. However due to the limited scope of the study, it was decided in supervision that documents directly identified on the wards involved in the study would be included. Further, the study did not request for ethical approval to access incident reports or patient complaints. Future research may benefit from including an analysis of these documents.

Analytical procedure

Ethnographic approaches utilise qualitative analytical methods (Griffin & Bengry-Howell, 2017). Thematic analysis is widely recognised as an effective method to analyse data in qualitative research and was used to analyse the interviews. Thematic analysis provides a process for identifying and organising patterns of meaning within data (Willig, 2013). It does not ascribe to a particular theoretical standpoint (Willig, 2013). The analysis followed guidance by Braun and Clarke (2006). All participants were assigned a pseudonym. The researcher read and re-read the transcripts, marking initial codes (see Appendix 12 for a coded transcript extract). The transcripts were subsequently re-read and the codes were grouped into meaningful themes (see Appendix 13 for an example of early coding). The researcher moved back and forth between the data and the codes. The NVivo data programme was used to assist the analysis process. The codes and themes were corroborated by the two supervising researchers of the study and a transcript was also coded by a researcher independent to the study, to contribute to credibility checking of the analysis.

The observations from the fieldwork were reviewed and used to comment on and further analyse the findings from the thematic analysis, being used as analytic points to feed into the interpretation of the data (Griffin & Bengry-Howell, 2017).

The document analysis also utilised qualitative research methods. Analysing texts within qualitative approaches involves reading and re-reading the material and identifying key themes to draw an image of the meanings analysed as being attached to the text. An informal approach to analysing textual cultural artefacts is recommended when this component does not form the key part of the research, but is complementary (Perakyla & Ruusuvuori, 2011). The researcher read and re-read the texts, picking out themes and relating these to the findings from the thematic analysis of the interviews and the analysis of the fieldwork observations.

Credibility checks and rigour

Rigour is enhanced in ethnographic research through taking an active, reflective stance throughout the entire research process, making modifications as required, supported through verification strategies, such as a concurrent active interaction between data and analysis (Morse, Barrett, Mayan, Olson, & Spiers, 2002). This constant back and forth between the data and the analysis occurred in this study by undertaking and transcribing the interviews whilst simultaneously carrying out further participant interviews and fieldwork.

A further technique for ensuring credibility is that of the use of triangulation (Tuckett, 2005). Triangulation can be used to demonstrate reliability of the analysis (Willig, 2001) and to support the corroboration of findings (Bowen, 2009), through triangulation of the methods used and through triangulation of researchers (Willig, 2001). Both were employed in this study, through utilising the use of three methods

of interviews, fieldwork observations and document analysis and also through corroboration of the themes undertaken by the two supervisors and a third independent researcher. Both supervisors and the independent researcher reviewed a cross section of transcripts and coded these. The codes were then cross-referenced with those identified by the main researcher. Divergences were discussed within the team and referring back to the raw data was again utilised to ensure the themes were rooted in the data.

The rigour of the study was improved by seeking the expert guidance of an experienced ethnographic researcher. Dr Hutchison provided consultation throughout the research process.

An opportunity for the participants to meet with the researcher to be presented with the findings from the study, in a format which is accessible to the participants, will be undertaken. The study did not seek to incorporate 'member checking' as it is argued that the process of abstracting and de-contextualising the data through being analysed by the researchers, can lead to participants being unable to recognise themselves or their experiences in the results (Morse et al., 2002). Member checking is also argued to attempt to identify a 'fixed truth', which is inconsistent with the approach of critical realism, which views reality as multiple and as open to change over time (Tuckett, 2005). Thus member checking did not align with the epistemological approach taken in this study.

Researcher perspective

Ethnographic approaches employ reflexivity to reflect and comment on the limitations and advantages of the impact that the researcher themselves has on the research (O'Reilly, 2012). A diary was kept throughout the research process to aid

reflexivity, in addition to a 'bracketing interview' which was undertaken by the researcher. This supported the use of 'bracketing', whereby researchers attempt to limit the amount that their own previous experiences shape the research (Fischer, 2009). However, it is acknowledged that the perspectives of the researchers will continue to shape the findings.

My interest in researching this area began when on placement at an acute mental health hospital during my clinical psychology training where I witnessed the use of restrictive practices on the ward. This placement shaped my own understanding of the inpatient psychiatric environment. This study took place at the same hospital where I was previously on placement, one year prior to the research commencing. I had not previously worked directly with any of the participants. To ensure that my experiences did not reduce the quality of the study, I utilised the research diary to reflect on this throughout the research process. During the analysis stage I also repeatedly made sure that I was immersed within the data by working closely with my supervisors during this stage. Having one researcher and two supervisors contributing to the project ensured that the analysis was rooted in the data, rather than being too heavily shaped by our personal backgrounds and interests.

Each of the researchers came to the project with their own cultural and social backgrounds. As a White British woman undertaking the research, I was aware during the period of data collection that my ethnic background was different to the majority of both the patient and staff participants. I reflected on this throughout the stages of data collection and analysis, attempting to ensure that my cultural background did not result in me making assumptions about the data.

The context brought by the researchers also includes the researchers' institutional contexts (Parker, 2002). As a trainee Clinical Psychologist, I have

received therapeutic training, which supported me in undertaking the research interviews. However, this also could have limited my ability to hear the participants' accounts from a perspective outside of the one I bring with my relationship to clinical psychology. By reflecting on this, I endeavoured to limit the extent to which this may have had on shaping the research.

The lead external research supervisor is a Clinical Psychologist and Lecturer in Clinical Psychology. He has previously undertaken research projects in the same hospital setting and has an interest in research in this area. The second external research supervisor is the Strategic and Clinical Lead for inpatient and acute psychology within the hospital where this research took place. She is also a Consultant Clinical Psychologist and has an interest in psychological research related to the inpatient setting. This research is carried out and informed by the academic context of University College London, as well as by the experience of working and undertaking the research within the organisation of the National Health Service. The current focus within policy on the reduction of restrictive practices may have further influenced my interest in focusing my research project on this subject.

Results

A brief contextual overview is presented to situate the results. The themes from the patient interviews are outlined first, followed by the staff member themes, as staff accounts often reflect upon the patient experience when describing their own account of restrictive practices. Interwoven into the themes from the interviews is the analysis of the observations made during the fieldwork component of the study. These will be linked to the themes from the interviews as appropriate and serve to

contextualise and enrich the results gathered from the interviews (Griffin & Bengry-Howell, 2017). Finally, the document analysis is outlined.

Supporting quotations from the interviews are provided to illustrate the themes, identified using pseudonyms. Paraphrased statements will be included from the fieldwork, also to illustrate the themes.

The findings from participants across the two wards are presented collectively, rather than separating these out by each ward, as an overall exploration of restrictive practices was the aim of the study, rather than to explore differences between the two wards.

Contextual overview

The wards on which this research took place are part of a large mental health hospital in a major UK city. A recent CQC (2017) inspection reported that in the area of implementing restrictive practices, the hospital was rated as 'requiring improvement'. At the time of the study, the female ward was one of two wards at the hospital taking part in a national initiative to reduce the use of restrictive practices. This programme is part of the Mental Health Safety Improvement Programme, established by NHS Improvement in partnership with the CQC. It aims to reduce restraints, seclusions, and rapid tranquilisations by 33% (Royal College of Psychiatrists, 2019). It entails reviewing the impact of various initiatives, such as increased presence and activities in the evenings and weekends. The fieldwork component of this study observed that this programme included the involvement of a select number of staff members on the ward and was discussed with patients in the weekly Community Meeting. A need to reduce restrictive practices may have been more pronounced on this particular ward due to this programme being in the early

stages of implementation, which may have informed the experiences described by participants on this ward.

Themes from patients' accounts

The themes were grouped into three domains including: the lived experience of restrictive practices; making sense of restrictive practices; and responses to restrictive practices. These broadly matched the research questions. Four themes were analysed from the patient accounts, with 10 sub-themes (Table 1). The number of participants who contribute to each theme is indicated in brackets in the table. The themes from patient accounts illustrate how patients describe experiencing restrictive practices being delivered coercively and involving de-humanising practices. The themes present an account of how patients make sense of the function of restrictive practices. Firstly, it is outlined how they are understood as rational and moral practices, with the need to ensure safety and manage risk. Secondly, they are contrastingly viewed of as immoral, where they may create increased aggression on the ward and where staff are protected from being held accountable. Finally, the themes outline responses to these experiences with survival strategies of surrendering and by breaking rules.

Table 1: Patient Themes

Domain	Theme	Subtheme	Detail / Illustrative quote
1. Lived experience of restrictive practices (9/9)	1.1 Overpowered by staff (7/9)	"Just playing their game"	"I was trying to get my way and I lost so now I'm just playing their game"
		Tactics	"you might find yourself feeling a bit upset, as I was [mm] but… well they use numbers as a tactic"
		Threats	"they would often check or threaten they might take your walks away"
	1.2 Dehumanising practices (9/9)	Locked in	"it makes me feel like a monster, like I've done something really wrong" "I don't know why we're treated like prisoners"
		Monitored by staff	"they watch us like toddlers"
2. Making sense of restrictive practices (9/9)	2.1 (Im)moral practices (9/9)	"To be protected to be safe"	"you're probably agitated and stuff, 'why are you holding me down?' but then it's for your own benefit" "it's their right to hold you down and take you to your room and inject you"
		Staff unaccountable	"They won't go to court either [yeah?] what they've done is allowed, nothing will happen to them, they'll keep on they just doing their job"
		Protection vs. provocation	"maybe they need to be restricted but if they weren't restricted in the first place I wonder if they were going to be that aggressive"
3. Responses to restrictive practices (9/9)	3.1 Survival strategies (8/9)	Surrender	"my spirit just said like forget about it who cares anyways just let him do what he wants"
		Breaking rules	"I do smoke in my room sometimes, I know I shouldn't do but you know otherwise you're waiting about two hours just to go out for a cigarette and by that time you're a bit sort of irate"

1. Lived experience of restrictive practices

1.1 Overpowered by staff

Patients described the ways in which they experienced being subjected to restrictions on the ward and the impact this had for them.

"Just playing their game"

An analogy of a 'game' was described when outlining how staff enforce restrictions:

> "*uh well at the beginning I was trying to get my way and I lost so now I'm just playing their game so yeah"* (Joseph)

After 'losing' at trying to get his own way, Joseph resigns to having to play "their game", suggesting that he is a player in someone else's game that he has no ownership over. Sarah also 'loses' at the game:

> *"cos as a patient you're never going to win"* (Sarah)

Sarah explains that there is never a chance of her 'winning' at gaining access to things such as *"whatever you're requesting really…a cigarette"* (Sarah, lines 108-109). It is interpreted that Sarah's experience of gaining access to everyday items such as cigarettes forms part of a 'game', to be won or lost. Both Joseph and Sarah here experienced not having a fair chance at winning and instead resign themselves to accepting that they will 'lose'.

Consequences of losing the game are provided by Joseph when describing being denied his leave if he did not comply with requests such as to undergo physical health checks:

> *"[…] I don't think freedom should be restricted but yeah obviously that's the game they play and that's the game you have to play and that's why like I said I'm playing their game now innit cos I've done everything they wanted, they basically raped me"* (Joseph)

He further explains:

"*they raped me by taking everything that I said I didn't want to give basically"*

He outlines what he had taken from him that he didn't want to give:

"blood, urine…vitals and whatever, the heart checks and stuff like that…it's like I'm their little experiment" (Joseph)

The game here develops into an "experiment", where Joseph becomes the powerless subject of the experiment. Joseph's experience of his freedom to leave being denied and having to undergo physical health checks is likened to a serious sexual assault, illustrating the severity of the intrusion and distress that Joseph experiences as a result of the 'game' of having to give in to staff demands. This implies that in reality, this is no fun 'game' at all for Joseph and instead has serious consequences.

Tactics

As is common within games, patients experienced staff as using 'tactics' whilst completing their tasks on the ward.

> *"[…] you might find yourself feeling a bit upset, um as I was* [mm] *but…well they use numbers as a tactic"* (Isaac)

For Isaac, the strategic use of increasing numbers of staff members when approaching him to administer medication is upsetting. During the fieldwork, Isaac was observed to use tactics himself in attempt to get his needs met, and informal conversation with Isaac led him to describe to me that by gathering other patients who might also want to request escorted leave from the ward, there was more chance that staff would facilitate this if there were a larger number of patients waiting to be granted leave. He was observed to move around the ward asking other patients if they wanted leave. Thus the use of tactics through increasing the number of people, for Isaac is experienced as a way to reduce the restriction of being locked on the ward, but is also experienced negatively when similar tactics are used by staff against him.

Threats

Patients described how they felt threatened by staff through the way in which restrictive practices were implemented when staff attempted to gain compliance from patients:

> *"basically I'm not allowed to leave before taking the medication"* (Munira)

"[…]if you don't give urine sample or do certain things they'll stop you from getting your leave" (Joseph)

"[…]they would often check or threaten they might take your walks away" (Chris)

Being denied leave from the ward is experienced as a threat used by staff to gain compliance for physical health checks or accepting medication. The fieldwork noted numerous occasions when patients wished to leave the ward but were not immediately able to. Mental health nursing staff are tasked with undertaking physical health checks with patients to contribute to the aim of improving overall care of patients experiencing distress who access mental health services (NHS England, 2016). Being granted leave here becomes intertwined with staff duties, such as physical health checks or accepting medication. This may suggest that patients feel coerced into providing these things in order to gain access to their "walks".

Sarah explains how she views staff as using the restrictive practices:

"I think for them [staff] it gives them structure um and sometimes they can use it [restrictive practices] almost like a weapon" (Sarah)

She goes on to explain:

"like if you've annoyed one of them then maybe they won't make your tea…you won't go down for that cigarette" (Sarah)

Here, Sarah experiences the "weapon" of restrictive practices in working as a way to control her behaviour, by ensuring that she does not 'annoy' staff. This "weapon" also affords staff the power to deny or permit certain activities such as having a cup of tea or a cigarette, as both of these activities required staff facilitation.

1.2 Dehumanising practices

It was analysed that patients felt dehumanised as a result of restrictive practices, where subjectivity was transformed into something unrecognisable through the implementation of restrictive practices, such as being on a ward that is kept locked or being closely monitored by staff.

Locked in

Sarah explains that *"if you're an informal patient you can just go, but if you're sectioned then you need someone to take you"* (Sarah, line 596), and how this led her to feel non-human:

> *"it makes me feel like a monster, like I've done something really wrong (.) like I'm gonna get out the building or I'm going to hurt somebody but I couldn't get out this building if I tried and I certainly wouldn't hurt anyone"* (Sarah)

The restrictions against Sarah's free movement in and out of the ward transformed her from being human to that of a "monster", with the ability to hurt others. Thus the experience of restrictive practices on the ward can be seen to

transform subjective identity into something scary, unrecognisable and for Sarah, something dangerous. This transformation of identity is further explored by others:

> *"I don't understand it I mean if you're a criminal and such things then I'd understand it a bit more but we're not we're not supposed to be criminals here know what I mean most of the people here have never been in prison so I don't know why we're treated like prisoners"* (Malik)

Malik feels as though he is positioned as a prisoner, despite not being a criminal. This is also explored by Joseph:

> *"{LAUGHS} well it's not my thing at all the the wards are crazy, it's a mad hole it's it's hell, it's hell on earth, that's how I consider it. It's the worse place to be man, I don't understand how they treating people… no way in hell that this sort of environment is going to heal someone. Like if they were going to do something properly they should at least take everyone to the park where nature is, where the healings at… not in close confinement as if you're in prison.* [mm] *Like you're saying that we're mental patients we got mental health problems how can we be kept inside in a cage it's like a cage we need to be outside in nature … not being in close confinement yeah"* (Joseph)

Joseph's experience of the ward as a "mad hole" and "hell on earth" illustrates how the environment is, for him, far from a place of "healing". Joseph contextualises this by comparing the environment to a prison and contrasts this with the 'healing' experienced when he is in "nature". For Joseph, the "close

confinement" is more representative of a prison or cage than somewhere people can move towards recovery. This matches existing documentation of experiencing the psychiatric ward as a prison (Goulet & Larue, 2018; Kanyeredzi, Brown, McGrath, Reavey, & Tucker, 2019).

Monitored

Patients also feel dehumanised as a result of monitoring practices:

"[…]I think they watch us like toddlers" (Sarah)

Sarah adds:

"yeah like you're talking to a child and we're not we're all equals it's just that some of us are ill" (Sarah)

The restrictive practice of surveillance leads Sarah to feel as though she is infantilised by staff and treated differently to that of an adult. This could be analysed as illustrating the powerful position occupied by staff, as experienced by Sarah. Sarah stresses that although the patients are experiencing an 'illness', they should still be considered as equals with the staff, and treated as such.

2. Making sense of restrictive practices

2.1 (Im)moral Practices

A process of understanding the use of restrictive interventions as either moral or immoral was analysed in the data.

"To be protected to be safe"

Restrictive practices were understood as ways to ensure safety and protect patients from harm:

> *"[…]whichever reason you're here for you're here you know to be protected to be safe"* (Aisha)

Aisha adds:

> *"[…]at the time yeah you're probably agitated and stuff 'why are you holding me down?' but then it's for your own benefit yeah"* (Aisha)

Restrictive practices here are questioned in the moment but understood as being in the patients' "own benefit", thus being understood as a moral act in providing care. This is further explored by Aisha:

> *"[…] if someone is refusing to take medication and stuff or they want to go out for fresh air you know it's their [staff] right to hold you down and take you to your room and inject you"* (Aisha)

Aisha constructs the use of forced medication and physical restraint as the "right" of the staff member, rather than describing the practices as being informed by the 'rights' of the patient. It is argued here that the positioning of restrictive practices

as the "right" of staff, positions the practices as a moral act. The restrictive practices are motivated by a moral duty to keep her safe, which is mirrored by other patients:

> *"[…]I was trying to bite the staff and they had to restrain me* [right] *and that was pretty terrifying but I don't remember an awful lot about it but I just remember being terrified but now I look back I had to be restrained because I was going to hurt myself or bite somebody"* (Sarah)

Restrictive practices are legitimised as a way of keeping patients safe. Despite this basis for the restrictive practices, they are simultaneously experienced as "terrifying" by Sarah. Similarly, whilst Mary identifies that being locked on the ward protected her from harm, it was experienced as *"a nuisance"* (Mary, line 301). Thus even when restrictive practices are viewed as a necessary strategy for ensuring safety, they remain a source of frustration for patients.

Restrictive practices were also rationalised on the basis of safety in terms of restrictions on what items patients are allowed on the ward or allowed access to:

> *"I'm not allowed to have a razor which is a shame* [right] *but I guess that's because of the reason that I'm in here. There's a lot of restrictions when you think about it but then a lot of them are for your own safety"* (Sarah)

Despite it being a "shame" that Sarah is denied access to a razor, this is countered by the need to ensure her safety. The restrictions placed on patients are thus legitimised by the need to ensure a safe environment. This was further corroborated during fieldwork observations of patients repeatedly requesting access

to mobile phone chargers, which were kept locked in the nursing station, due to the risk to patients posed by the chargers.

Staff unaccountable

The implementation of restrictive practices was seen as something that staff would not get into trouble for doing:

> *"yeah and they won't go to court either* [yeah?] *what they've done is allowed nothing will happen to them they'll keep on they just doing their job"* (Chris)

Chris goes on to explain what he thinks about this:

> *"well I think it's disgusting"* (Chris)

Chris views it as "disgusting" that staff members cannot be held accountable for their role in implementing restrictive practices. This constructs the practices as being viewed of as illegitimate or immoral and that staff should be required to answer to their actions in a court of law, which positions staff as potential criminals. Instead, Chris experiences a sense of powerlessness whereby he can't challenge the actions made against him. Providing accessible information regarding patients' rights to raise concerns, complaints and compliments as well as having access to their own health records, are key standards to be delivered within the first 12 hours of admission to inpatient psychiatric wards (Perry, Palmer, Thompson, Worrall, & Chaplin, 2017), however Chris's experience illustrates an inability to raise his concerns.

This analysis of staff as being protected from shouldering responsibility for the actions is explored by Chris when sharing an additional experience of being restricted:

> *"and they forced me back into the hospital, but at the same time they were saying to me to just keep calm!"* (Chris)

The intonation used by Chris during this account was interpreted by the researcher as one of incredulity. Using the phrase "*but* at the same time" (my italics), it is interpreted here that Chris experiences the act of being "forced" back to hospital as incompatible with 'keeping calm'. This instruction from staff is seen to place the responsibility within Chris by implying that he has the ability to remain calm and in turn to make the forced admission a more bearable experience. It could be questioned here whether Chris has any power to 'remain calm' and whether being told to do so is more for the benefit of the staff member than for Chris as it places blame within Chris for making the situation worse by not remaining calm.

Protection vs. provocation

It was questioned as to whether restrictive practices either resolve, or exacerbate aggressive behaviour:

> *"yeah if some of them are quite aggressive some people here are quite aggressive so (.) maybe they need to be restricted but if they weren't restricted in the first place I wonder if they were going to be that aggressive in the final instance kind of thing"* (Malik)

Malik here is wondering whether restrictive practices lead to an increase in aggression amongst the patients. It could be argued that the restrictive practices provoke aggression, rather than being a moral response to managing aggressive behaviour and ensuring safety on the ward. Thus restrictive practices can be viewed from multiple, and at times conflicting perspectives.

3. Responses to restrictive practices

3.1 Survival strategies

A variety of strategies were identified within the data as providing patients with ways of coping with the impact of the restrictions encountered on the ward.

Surrender

For some patients, it was seen that a coping strategy was that of giving up, relenting, or surrendering to the process.

> *"uh when I got injected the guy did it with force and I tried telling him don't do it with force like you done last time and then he pricked it in my bum cheek bare hard"* (Joseph)

Joseph's request here for an approach without "force" was not felt to be granted. Joseph goes on to reflect how he managed this:

"just what's wrong with him? I wanted to punch him but my spirit just said like forget about it, who cares anyways just let him do what he wants, there's something wrong with him" (Joseph)

Initially this situation elicits a strong anger response in Joseph. However, to manage it, Joseph describes intentionally deciding to "forget about it" and instead views the staff member as having something wrong with him. It is possible that Joseph sees no value in challenging what happened, but instead accepts it and tries to forget it, he surrenders to the situation by letting the staff member "do what he wants".

Breaking rules

A second survival strategy for some patients was identified as breaking ward rules in order to diminish adverse effects, such as frustration from not being able to smoke. Karl explains what he does when he is not allowed out of the ward:

"yeah hence why I do smoke in my room sometimes I know I shouldn't do but you know otherwise you're waiting about two hours just to go out for a cigarette and by that time you're a bit sort of irate [yeah] *and stressed so"* (Karl)

The stress experienced as a result of not being granted leave for a cigarette for a prolonged period of time results in Karl breaking the rule and smoking in his room. Karl's account paints a picture of his room being a place of private respite in which he has greater power and agency to meet his needs and reduce his levels of

stress. Breaking this rule could be seen to be Karl taking action to manage his own experiences of stress and feeling “irate”.

Themes from staff members’ accounts

The analysis of the staff member accounts produced six major themes and 13 sub-themes (Table 2). These were grouped into three domains: making sense of restrictive practices; lived experiences of restrictive practices; and strategies to avoid the need for restrictive practices. There were some similarities and some differences across patient and staff themes. The themes begin by illustrating the way in which restrictive practices are experienced as legitimate practices, through the need to ensure a safe environment and manage risk. These are validated through being outlined in ‘policies’. The second domain explores the professional and personal impact of restrictive practices. The final domain outlines the ways in which staff describe attempting to utilise alternative practices such as -de-escalation’ and also by adopting a humane approach.

Table 2: Staff themes

Domain	Theme	Subtheme	Detail
1. Making sense of restrictive practices (8/8)	1.1 Legitimate practices (7/8)	Protecting safety and managing risk	"…the patient poses a danger to himself and the rest of the peers and even the staff so they restrain"
		Legitimised through policy	"we have to make sure we go according to the policies"
	1.2 Ward environment (6/8)	Safe environment vs. threatening environment	"…instead of viewing it as somewhere safe and somewhere containing it's somewhere… they can feel quite threatened"
2. Lived experience of restrictive practices (8/8)	2.1 Professional impact (8/8)	Perceived of as uncaring	"don't think you are caring for them, they think you are actually encroaching, you know, their rights"
		Therapeutic alliance 'damaged'	Restraint "can then damage that service user's trust in clinicians"
		Structural challenges	"staff not being able to follow through"
	2.2 Personal impact: "Emotionally troubling for staff" (6/8)	Overwhelming	"it's very overwhelming"
		Guilt	"oh what have I done?"
		Sadness	"it's kind of sad for us"
3. Strategies to avoid the need for restrictive practices (8/8)	3.1 Alternative practices (8/8)	"Negotiation" and "de-escalation"	"with calm words you can de-escalate so many issues"
		"Know the reason why"	"you need to know the reason why this person is acting this way"
	3.2 Adopt a humane approach (6/8)	Empathy	"we have empathy for them"
		Advocate	

1. Making sense of restrictive practices

Staff members provided accounts of how they made sense of restrictive practices.

1.1 Legitimate practices

Restrictive practices were constructed by staff as valid and legitimate practices.

Protecting safety and managing risk

Mirroring the patients' construction of restrictive practices as being necessary to ensure safety, staff also spoke about the use of restrictive practices as providing a safe environment and managing risk issues.

> *"[…]they hardly restrain but they restrain sometimes and um that is um an extreme issue when they when the patient poses a danger to himself and the rest of the peers and even the staff so they restrain"* (Leena)

Leena explains that restraints are "hardly" used and only done so in "extreme" cases, when patients present a danger to members of the ward. Leena continues:

> *"[…]and um I realise for the few people I've seen them restraining they they they behave you know they take the correction"* (Leena)

Leena experiences the restraint as an effective way to 'correct' the patient's behaviour. It is analysed that Leena experiences the patients responding to the

restraint with the desired effect of the challenging behaviour being changed, or managed, being motivated by keeping people safe.

Mara similarly views restraint as a safety measure, but highlights that patients do not experience restrictive practices in the same way as staff:

> *"[…]I will see it from the caregiver perspective they will see it from service user perspective, I am seeing it as I am trying to prevent harm from happening but they're not seeing it that way"* (Mara)

Restrictive practices are here constructed as carrying different meanings for patients and staff, where for staff they function as practices which "prevent harm", but this view is not shared with patients.

Kate outlines how risk assessment informs the decision process when deciding whether or not to implement a restriction, such as providing a cup of tea:

> "*[…] it's either we look at the risk and see if it's actually good to give that, because at times we give someone a hot tea or coffee they'll just chuck it on your face and burn you, so you have to think about, is it right to give?"* (Kate)

The process of assessing risk illustrates the function of restrictive practices as serving to ensure safety and how this informs the decision process when implementing restrictive practices.

Legitimised through policy

Policies formed a key role in authorising the use of restrictive practices. Here Barbara explains how the "policies" help her to legitimise the need to restrict patients.

> *"they just say 'I need to go out now'* (said slowly) *... yes I know patients should be treated by choice and as unique individuals but at the same time you know it's a hospital they lay down policies and things that should be adhered to as well so, but sometimes when you pass on this message to them sometimes they listen and sometimes they don't"* (Barbara)

"Policies" directly inform Barbara's practice and the implementation of restrictive practices, such as denying leave. This is analysed as constructing the practices as being embedded within guidelines that have been set out by others. Barbara separates herself from these policies by becoming the messenger passing on the rule of the policy. This may serve to diminish her sense of responsibility at having to deny the patient's leave. Barbara also positions the legitimacy of the policy as over that of meeting the patient's 'choice', indicating the power held by the policies.

During the fieldwork, a discussion between staff took place in the nursing station, which similarly explored the role of policy in providing guidance regarding restricting access to items. It was discussed amongst staff that other hospitals had different policies, when Mara spoke of her experience of working for a different hospital where patients had unrestricted access to hot water and coffee and tea making facilities. Pros and cons were identified by Mara, with saving time being a

pro, and risk concerns and financial expense to the trust being a con. Thus it was experienced that policies are variable across different settings.

Harry explores the role of policies in detaining patients on the ward:

> *"when a patient is on a certain section we have to make sure you know we go according to the policies because you're not keeping the patient because you want to keep the patient, you're looking at the community where the patient is going to go"* (Harry)

For Harry, the "policies" provide a framework for justifying the use of the restrictive practice of detaining a patient on the ward, again validated by the need to ensure safety. It could be analysed that identifying the policies, rather than the laws which underpin this restrictive practice, could illustrate an unwillingness to name what is actually happening, in terms of staff implementing laws of the state to detain individuals. This may result in distancing the staff from feeling as though they are responsible for implementing these restrictive practices as enforced by law.

Policy also informs the use of restrictive practices through interventions such as patients' individualised care plans:

> *"so long as a restrictive practice is care-planned then it's fine yeah"* (Mara)

This highlights the authority attributed to the care plans in permitting certain interventions. It also constructs restrictive practices as "fine" and acceptable if included in this document.

1.2 Ward environment

Safe environment vs. unsafe environment

Conflicting views of the role of restrictive practices in creating a safe or an unsafe space were given:

> *"[…] [restraint] settles other patients on the ward, it also helps to settle the ward, it makes it calm and um collected"* (Kate)

Kate here identifies her view of restraint as helping to create a 'calm and collected' environment. However, in contrast, Sophie sees things differently as instead of contributing to the feeling of safety on the ward, she expresses that witnessing or experiencing restrictive practices may lead patients to feel less safe:

> *"it [restraint] can damage the way they view the ward as a whole. Instead of viewing it as somewhere safe and somewhere containing it's somewhere that actually you know things can escalate to that level and they [patients] can feel quite threatened … I think it's quite scary for everyone involved"* (Sophie)

The impact of witnessing restrictive practices leads patients to feel scared and threatened on the ward, creating an image of an unsettling and frightening space, in stark contrast to Kate's vision of a 'calm and collected' ward. This contrast in accounts highlights the complex nature of the experience of restrictive practices for staff.

Similarly to the experience of restrictive practices as transforming the ward into a frightening place for patients, staff describe experiencing the ward as a threatening place to work:

> *"[…] you just got to be careful about patients, in case, you know, in case they do attack you and stuff like that, I've had I've had two attacks already since I've been here"* (Yalina)

Yalina here notes how staff need to "be careful" when on the ward, suggesting that patients pose a risk to her safety. Making the decision to implement a restrictive practice such as restraint is often informed by analysis of the risk of violence and lack of safety for members of the ward (Riahi, Thomson, & Duxbury, 2016) and staff who have been injured during a restrictive practice are more likely to restrain later in an episode of aggressive behaviour than those who do not have previous experience of injury (Moylan & Cullinan, 2011). Thus experiencing assaults and the ward as a threatening environment may influence the use of restrictive practices.

The impact of the 'abuse' experienced by staff is described as impacting on how the job is carried out:

> *"it gets to us really badly, like despite the professional aspect of it, we're human so you still feel that if someone calls you that, verbally abusing you, you still feel hurt and try to mask it, you know and carry on with the with the job"* (Barbara)

Mental health acute staff are seen to stoically accept the likelihood of experiencing potential violence in this setting (Totman, Lewando Hundt, Wearn, Paul, & Johnson, 2011). Barbara's 'masking' of the "hurt" that she experiences is analysed as being a stoical response and carrying this "hurt" may influence how staff deliver care on the ward.

2. Lived experience of restrictive practices

2.1 Professional impact

Perceived as uncaring

One of the ways in which restrictive practices make it challenging to work on the ward is seen in how staff experience being perceived as uncaring by patients, due to their involvement in restrictive practices.

> *"[…] initially when you bring them here they don't think you are caring for them they think you are actually encroaching you know their rights"* (Anita)

Anita describes how initially patients cannot identify what she is doing as care, instead this is experienced as an 'encroachment' on their rights. This inability for patients to identify the staff as caring for them is managed by staff by adopting the approach whereby Mara outlines: *"we overlook it"* (Mara, line 192). This is reminiscent of the earlier analysis that staff adopt a stoical approach to the care they deliver.

Kate outlines how patients feel as though they are in prison when they are denied things they request:

"[…] some would also want to go downstairs to go for fresh air, if they don't get that they think they are in prison, they keep using bad language verbal abusive that they are in prison, but it's not because they are in prison they are not in prison but it's because they do not have section to go out for fresh air" (Kate)

It could be interpreted that holding the position of power and responsibility in terms of reinforcing restrictions on patients, for example through enabling or denying leave, Kate's role is transformed from that of carer to that of prison officer. This mirrors the patient reports of themselves feeling imprisoned and treated as criminals as outlined earlier.

Therapeutic alliance 'damaged'

Restrictive practices are experienced as negatively impacting on the therapeutic alliance between staff and patients, making it challenging to maintain a positive rapport.

"[…] especially if they have past difficult experiences, traumatic experiences, to go through that [restraint] it can be really traumatising and distressing so it can then damage that service user's trust in clinicians" (Sophie)

Sophie reflects on the distress of being subjected to restrictive practices as damaging the trust between staff and patients. This rupture is also explored by Mara:

"[…] it strains that relationship that you have with them, like they see it like a punishment like you've done something to them against their will" (Mara)

When administering a restrictive practice, Mara experiences herself as being positioned as the person subjecting the patient to punishment, she becomes the 'persecutor' in the patients' eyes, which strains the therapeutic relationship. Barbara similarly experiences a strain on the relationship after being involved in a patient receiving forced medication:

"[…] when the injection is given and they see you and you are part of the team <u>YOU</u>, you were one of them you did that to me and you now and you explain and explain why the injection had to be given it wasn't to it's not like punishment, it's medication … for the patient to get better" (Barbara)

The use of forced medication here is explained to the patient as a factor in helping them to move towards recovery. Communicating by 'explaining and explaining' attempts to repair the damage to their therapeutic relationship. During an informal conversation with Barbara during the fieldwork, she describes attempting to rebuild a ruptured therapeutic alliance with a patient following a restrictive practice by offering a 'de-brief' and 'kind of apologising' to the patient. This may suggest that Barbara experiences a sense of responsibility at implementing the practice, but that giving a rationale for the practice reduces this sense of responsibility and helps to repair the rupture.

Sophie reflects on how her role of Assistant Psychologist protects her therapeutic alliance with patients as she is not responsible for carrying out restrictive practices:

> *"I'm not in charge of who gets to go on leave or what medication they have to take so I guess I'm in the position where maybe it's a bit easier sometimes to have those therapeutic relationships"* (Sophie, lines 104-105).

This highlights that maintaining a therapeutic alliance is more challenging for staff involved in facilitating restrictive practices.

Structural challenges

Structural challenges such as service-level issues of being short-staffed are highlighted as a factor in the experience of restrictive practices.

> *"sometimes we have a shortage of staffing…if there is an appointment or like just shopping and you are unable to facilitate that…because the shopping might mean so much to the person…and then end of the day you realise that you're unable to do it so that's disappointment in not meeting someone's uh need"* (Anita)

For Anita, being unable to facilitate a planned shopping trip for a patient due to staff unavailability leads her to feel "disappointed". The problem of being short-staffed leads to further restricting the activities of patients, which has a negative emotional impact on staff. This was similarly explored by Sophie:

"[…]the nature of the ward it's so … staff not being able to follow through with promises that were made um yeah which I think just makes people feel even more restricted" (Sophie)

When promises are not able to be kept, due to staff being too 'busy' people feel "even more restricted", illustrating how staff identify that being unable to meet patient needs results in further experiences of patients feeling restricted. Staff morale is negatively affected by experiencing high levels of pressure. Heavy workloads may also prevent staff from attending supervision and training (Totman et al., 2011), which may impact on their skills in effectively delivering care.

2.2 Personal impact: 'Emotionally troubling for staff'

Staff discussed how ward work can be "emotionally troubling for staff" (Barbara, line. 23).

Overwhelming

Staff members described feeling overwhelmed by the experience of implementing restrictive practices:

"[…]whenever we use restrictive practice it's very overwhelming for different, because we don't, it's not as if we want to see someone being held and being, it's, it kind of affects us" (Mara)

Restrictive practices are identified as contributing to some of the most challenging aspects of the job:

> *"[…] I think restrictive practice, like restricting people on the ward is some is one of the things I struggle with the most"* (Sophie)

Restrictive practices therefore present a significant challenge to working on the ward. This is mirrored in the literature where there is an ethical struggle experienced by staff between maintaining safety and delivering interventions that they dislike (Riahi et al., 2016).

Guilt

For some staff, it is analysed that troubling feelings such as guilt were experienced in the context of restrictive practices:

> *"[…]yeah that feeling of 'oh what have I done?' you know, and when you're doing it… sometimes they resist…that does get to us sometimes"* (Mara)

By questioning what she has done, it was analysed that Mara experiences a sense of guilt in her role of implementing restrictive practices, which is amplified when patients show signs of resisting the intervention. This sense of guilt is identified within the literature (Gelkopf, Roffe, & Behrbalk, 2009). However Mara explains how the use of de-briefs and explaining to the patient why the restrictive practice was implemented helps her to manage these feelings:

"you haven't done something bad, know what I mean [yeah], so the debriefing it helps" (Mara)

It is analysed here that debriefing helps Mara to ease the sense of guilt. Thus a process of rationalising the use of the techniques is seen here to support Mara in emotionally processing her role.

Sadness

Utilising restrictive practices can also lead to emotional responses of sadness and can be upsetting for staff:

"[…]people don't like being restrained generally so staff having that frustration or distress directed at them if they're involved in the restraint, that can be upsetting" (Sophie)

"[…]it's kind of sad for us" (Mara)

Staff identified experiencing feelings of sadness as a result of having to implement restrictive practices. Delivering restrictive practices therefore has negative consequences for staff, which is mirrored in existing literature that highlights the traumatic nature of restrictive practices for staff (Bonner, Lowe, Rawcliffe, & Wellman, 2002).

3. Strategies to avoid the need for restrictive practices

3.1 Alternative practices

"Negotiation" and "de-escalation"

Staff described delivering practices which were felt to reduce or prevent the need for restrictive practices. Techniques aimed at 'de-escalation' were described by staff with an aim to prevent the need for using the more severely restrictive interventions such as restraint and forced medication. Staff members spoke of the initiative of 'Safewards' (Bowers, 2014) and the approach of using 'soft words':

> *"[…] with safe ward I just advocate don't use the last measure…we try to use the soft words you know the positive talk, talk down and engage with communication, activities to engage them because then are you are dealing with them humanely"* (Anita)

Anita positions restrictive practices as a 'last resort', illustrating her preference for utilising other methods whenever possible and only using the more restrictive interventions when necessary. Anita emphasises how de-escalation is a 'humane' approach and thus it is understood that Anita experiences using these approaches as more compassionate and humane than other more restrictive practices.

Kate outlines how de-escalation techniques provide her with what she describes as a form of 'negotiating' with patients:

> *"[…] using de-escalation is better um, negotiating with the person um because it's better that way than to order, like I'm telling you to do this, that's not the right way"* (Kate)

Kate provides an example of how this negotiation may work:

"she was refusing that depo [medication in the form of injection] *but she wanted to go out and have a smoke, so we said it's either you have the depo or you're not going … [after] one hour 'okay can I have the depo now?' {LAUGHS} so that kind of negotiation does help"* (Kate)

"Negotiation" here supports Kate in gaining compliance from the patient. Defining this as a 'negotiation' suggests an equal discussion between staff and patient. It could be interpreted that the experience of this interaction for the patient may not be experienced as a form of negotiation, but rather as a form of coercion, as documented in the patient analysis above. However, this not recognised by the staff member here. Thus techniques aimed at reducing the negative impact of restrictive practices may not be experienced as less coercive by patients.

The technique of de-escalation is also conceptualised as not always having the desired effect:

"[…]sometimes when you try to de-escalate some of them some of the patients they (.) it makes the (.) it makes them go, go more angry, they don't even want to talk, don't say anything…they could harm themselves in the process so I think that is when things like restraining comes in" (Leena)

It is analysed here that the de-escalation technique is not always viewed to be effective and may cause some patients to experience increased anger, which is the opposite of what is aimed for. This suggests that each patient may respond to the methods differently, with the methods being perceived differently by patients. Leena

also rationalises the use of restraint as being to prevent harm to the patient when anger continues to be an issue in the case of failing to de-escalate the situation, despite efforts made by the staff member.

"Know the reason why"

A consideration of the patient's past traumatic experiences was given when making sense of the challenging behaviour that patients sometimes displayed and was seen as key in reducing restrictive practices through informing decision making:

> *"you need to understand their behaviour you know you need to know the reason why this person is acting this way ... what they went through before and then if you understand then you can have a care plan to help you to manage that challenging behaviour"* (Anita)

It is read here that Anita's focus on understanding the underlying factors involved in the displayed behaviour helps her to make sense of behaviour that is experienced as challenging. Anita's approach is reminiscent of Positive Behaviour Support, which emphasises the need to assess and understand underlying causes for the behaviour, rather than solely reacting to the behaviour itself and has been positioned as a suitable alternative or prevention method to restrictive practices (Hamlett, Carr, & Hillbrand, 2016; LaVigna & Willis, 2012). During the fieldwork, Barbara similarly disclosed that she reflects on how being subjected to a restrictive practice such as a restraint may trigger flashbacks to previous traumatic incidents such as sexual abuse, illustrating how she focuses on building an understanding of the presented behaviours.

3.2 Adopt a humane approach

Empathy

Staff members outlined that *"we have empathy for them"* (Kate, line 381) and it was analysed that staff members would adopt an empathic approach when reflecting on the use of restrictive practices, often by putting themselves in the position of patients. Barbara illustrated this in an informal discussion during the fieldwork when she spoke about how it is 'good to remember what it's like for the patient' in terms of considering the significant impact that restrictive practices may have on the patient. Empathising with patients is further explored by Kate:

> *"[…]when I did the training where they have two people are holding you, no it's not a nice experience personally, so I don't think it will be nice for them when it's being done to them so I'm sure on the wards they try to avoid that kind of thing but… it's very difficult but I, it's best not to apply that, this is what, like in the worst circumstance, that you need to apply that restraint, it's not a nice thing to do"* (Kate)

Being empathic towards the experience of patients when being restricted is linked to efforts made by staff to use restrictive practices only as a last resort. Staff also are able to connect to patients as humans by empathically reflecting on the experience of restrictive practices:

> *"we try as much as we can at the end of the day as I said we're all humans I wouldn't want someone like holding my hands and pulling me down…"* (Mara)

Advocate

Staff also discussed being "*an advocate of non-restrictive practices"* (Anita, line 201). Anita goes on to say why this is:

> *"because restrictive practices is for me is too aggressive. Number 1 it does not empower people and then it doesn't give them choice and it does not promote independence"* (Anita)

Sophie similarly talks about how informing patients as to why they are being restricted can help the patient to feel as though she is advocating for them:

> *"I think yeah it's better to feel that at least people are listening and people are planning and even if the decision is still the same at least support has been put into it rather than people feeling 'I have no control and no one's like advocating or supporting me' or not knowing the reasons for something"* (Sophie)

Being able to advocate for patients supports staff in the aim of preventing the need for utilising restrictive practices.

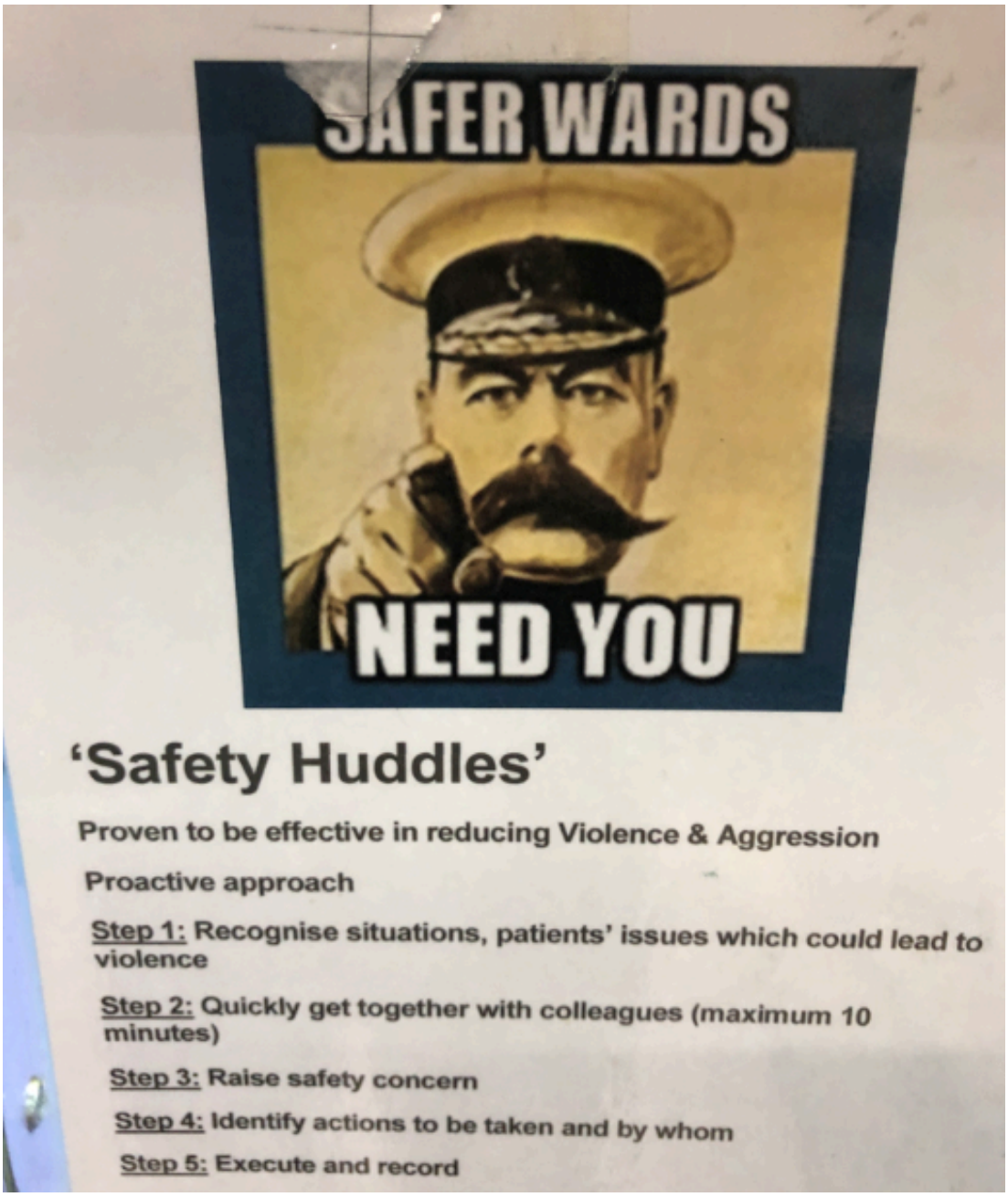
Document Analysis

During the period of fieldwork, local documents that were experienced as relevant to the study were identified. This led to two posters being included. Poster 1 was placed on the entrance to the first locked door to both wards and Poster 2 was placed in the Nursing Station on the male ward.

Poster 1: Welcome Ward Visitors

Being informed that the doors are locked for 'security reasons' implies that measures have to be taken to ensure safety is upheld on the ward. The rationale for taking the measure of keeping the doors locked is stated as being due to ensuring the safety of the vulnerable patients. It is analysed that this fits with the patient and staff rationalisation of the use of restrictive practices in the ward as being driven by a need to ensure effective risk management and safety are upheld at all times. It is analysed that this poster, which is seen by patients, staff and by the visitors of patients serves to endorse the narrative of the ward as being a potentially unsafe place and that measures such as the locked door are viewed of as being a rational and needed response that is driven by the best intentions of keeping patients safe.

Poster 2: 'Safer Wards Needs You!'



This poster, outlining the aims of staff 'safety huddles' was observed to be in the nurses' station on one of the wards. A 'safety huddle' was observed as part of the fieldwork on numerous occasions. This took place in the morning and consisted of staff coming together for a short period of time. One staff member presented new admissions, any recent incidences of aggression or violence and reminders to remain

as visible as possible on the ward. It was also observed to be an opportunity to emphasise adopting a kind approach both towards patients but also between staff members.

The poster incites a reminder of the advertisement drive used in World War I to increase recruits to support the army during the war. It has since become a well-used image in the UK and has been somewhat removed from the past link to army recruitment. However, the main image on the poster and the language invoking the now famous image could be argued to construct the role of the staff members as likened to army recruits, having to work together as a team to manage the violence and aggression encountered on the ward.

However the text underneath the image on this poster focuses on supporting the use of prediction and de-escalation. It is analysed that the focus on these methods mirrors the analysis of the interviews whereby staff members place significant importance on the use of prevention and de-escalation as tools in supporting staff to work as humanely as possible with patients, with the unspoken aim of reducing the need for more restrictive practices such as restraint, by reducing violence and aggression. This poster therefore reinforces the staff theme of the role of prevention and de-escalation in reducing the use of restrictive practices.

Discussion

This study explored the experience of restrictive practices within an inpatient acute psychiatric setting from the perspectives of patients and staff. Utilising ethnographic methods, it sought to build an understanding of the experience of restrictive practices from multiple viewpoints. The study asked two questions: ‘how do patients and staff experience and make sense of restrictive practices?’; and ‘how

do patients and staff respond to restrictive practices?'. The study presented insight into the ways in which restrictive practices are experienced and understood from the perspectives of patients and staff. It highlighted some similarities between the accounts and also key differences. Possible implications for these accounts are discussed.

Differing accounts of restrictive practices

This study allowed participants to discuss the practices that they experienced as restrictive, rather than providing a set definition of restrictive practices. The focus given to different types of practices discussed by patients and staff varied. Whilst staff accounts of restrictive practices focused more on the most restrictive of practices such as physical restraint or methods to avoid restraint, patient accounts were saturated with experiences of being denied leave for cigarette breaks, access to tea and coffee and the ways in which staff gained compliance for everyday tasks such as taking medication and undergoing physical health checks. This has significant implications for understanding how to improve the experience of inpatient care through a need to focus not only on the most restrictive practices, but also on the 'less' overtly restrictive practices.

'Negotiation' or 'threat': divergence in experiences of 'de-escalation' techniques

A key finding from the study related to the use of techniques to prevent the use of restrictive practices. For staff, the use of de-escalation techniques including 'soft words' and 'negotiation' formed an important way in which they delivered care. These approaches were seen to prevent or reduce the need for implementing restrictive practices, and were experienced by staff as being more 'humane'. These

methods correspond with current guidance on utilising the 'least restrictive option' (Department for Constitutional Affairs, 2007). However, the de-escalation methods were experienced in contrasting ways by staff and patients. Interactions utilising 'de-escalation' were simultaneously described by staff as constituting a 'negotiation' between staff and patients, whilst being experienced by patients as a 'threat' made by staff towards patients. This was often experienced whereby the efforts to gain leave were intertwined with compliance with nurse-led goals such as the completion of physical health checks or the administration of medication. Thus instead of experiencing de-escalation techniques as a 'humane' approach, as they are conceptualised by staff, for some patients 'negotiation' is experienced as a form of coercion. This finding is significant, as attempts to improve the experience of inpatient care are currently driven by a need to reduce restrictive practices, through the use of less restrictive practices such as de-escalation methods. If alternatives to restrictive practices, such as those of de-escalation techniques are also experienced by patients as coercive, the experience of care may not be improved. This highlights the need to consider the patient experience of all forms of intervention, including less overtly coercive acts, as only those experiencing the acts can determine whether or not they are coercive (Newton-Howes & Mullen, 2011).

Examining the gap between staff and patient accounts has been identified as necessary in understanding the enduring dissatisfaction with inpatient care (Wood, Williams, Billings, & Johnson, 2019). Additionally, a need to address power imbalance within communication techniques utilised by mental health nurses has been noted (Cleary, 2003). The findings highlighting the diverging ways in which de-escalation techniques are experienced by staff and patients may contribute to

developing appropriate strategies to reduce restrictive practices and improve the experience of care.

Perceived contrasting views on the role of restrictive practices

A further finding was that restrictive practices were viewed by both patients and staff as serving to ensure safety. This provided a legitimate explanation for the presence of restrictive practices on the ward and is consistent with existing literature (Chow & Priebe, 2013; Muir-Cochrane, O'kane, & Oster, 2018). However, despite both patients and staff rationalising the use of restrictive practices in this way, some staff members felt that patients did not share this conceptualisation of restrictive practices. This discrepancy in how restrictive practices are understood to be experienced by patients from the staff perspective suggests that conceptualisations of restrictive practices are not communicated between patients and staff. This could have consequences for example in contributing to staff experiences of being viewed of as persecutors rather than as carers by patients.

Communication

Issues related to the experience of communication between patients and staff in relation to restrictive practices were noted throughout the findings.

Communication and the therapeutic alliance

It is analysed that the ways in which restrictive practices are experienced by patients and staff has a negative impact on the ability to build a positive therapeutic alliance. This is also consistent with existing literature (Gilburt et al., 2008; Gumley, Braehler, Laithwaite, Macbeth, & Gilbert, 2010; Knowles, Hearne, & Smith, 2015).

A therapeutic alliance is characterised by a collaborative bond between patient and therapist that incorporates warmth, empathy and trust, supporting effective communication and shared goals (Beck, Rush, Shaw, & Emery, 1979). However, it is analysed that the subject positions that both staff and patients feel they are ascribed on the ward limits the ability to work collaboratively and form shared goals. The multifaceted role that nurses occupy within the inpatient psychiatric setting presents challenges to building therapeutic alliances with patients, whereby taking on the dual roles of "custodian and therapist, may conflict with each other" (Clarke & Wilson, 2009, p.145). Patients as prisoners and staff as persecutors presents a power imbalance, which can make developing a collaborative approach more challenging. This has significant consequences for the delivery of care in this setting as the therapeutic alliance is central to reaching a positive therapeutic outcome (Gallop, Kennedy, & Stern, 1994; McCabe & Priebe, 2004), as well as in supporting the creation of an environment that is experienced as safe (Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013).

Subject positions

Prison life

Consistent with existing literature, a key finding was the experience of restrictive practices within the inpatient psychiatric setting as being likened to that of being imprisoned (Goulet & Larue, 2018; Kanyeredzi et al., 2019). This mirroring of the prison environment contributed to the transformation of subject positions experienced by both patients and staff. For patients, they felt treated as though they were prisoners, monsters, or children. Staff reported feeling as though they were experienced by patients as carrying out punishments instead of care.

Also contributing to the discourse of comparing inpatient psychiatric life to prison life was the analysis of the cultural artefacts of the two posters. The first poster positions patients as vulnerable, with this vulnerability serving to legitimise the need to keep the ward doors locked, despite this hospital not being a 'locked ward' in terms of the legal status of the hospital. The second poster drew on army narratives to encourage staff to monitor and manage the challenging behaviours presented by patients. Thus it is seen that the prison, or war-like discourse is present not only in the lived experience of restrictive practices on the ward from the perspectives of both patients and staff, but is also presented to members of the ward in written documents, which is analysed as having the potential to further endorse this impression of the ward as experienced by patients and staff.

Cognitive dissonance

The complex position for staff in wanting to provide humane care yet having the task of implementing restrictive practices has been noted elsewhere to lead to cognitive and emotional dissonance in mental health care staff (Chambers, Kantaris, Guise, & Välimäki, 2015; Staniulienė et al., 2013). It could be seen that both patients and staff experience cognitive and emotional dissonance as a result of feeling ascribed to particular subject positions. Cognitive dissonance outlines how pairs of cognitions that are experienced by an individual to be the opposite of each other, are experienced as psychologically uncomfortable and motivates that individual to make adaptations to reduce the discomfort from the dissonance (Festinger, 1962). Individuals experiencing cognitive dissonance may act to avoid further information that increases the dissonance. Thus the distancing from restrictive practices analysed in this study may be an act to avoid further cognitive dissonance.

The subject positions identified by patients and staff of prisoner and persecutor, are experienced as ego-dystonic and it is analysed that individuals attempt to distance themselves from the restrictive practices on the ward which contribute to leading to these subject positions. Patients do this by using strategies such as surrendering to the demands of staff to protect themselves, or breaking ward rules in order to meet some of their needs. Staff attempt to distance themselves from the delivery of restrictive practices by constructing them as being legitimised through policy. It is argued that this serves to reduce the sense of personal responsibility experienced when implementing restrictive practices. Additionally, patients are analysed in this study to experience an expectation from staff for them to 'remain calm' during the implementation of a restrictive practice. This is analysed as being experienced by patients as an unrealistic expectation. It is argued that this may lead to a sense of responsibility being experienced by patients, whereby the onus is placed upon the patient themselves to manage their distress.

Limitations

Several methodological limitations require consideration. One limitation of this study was the use of convenience sampling and the consequential lack of representation of staff members across all disciplines on the ward. Whilst a range of clinical staff took part in the semi-structured interviews, the role of the psychiatrist was absent. This may be significant as the psychiatrist customarily holds responsibility for making significant decisions regarding a patient's care, such as whether or not they are admitted under a section of the Mental Health Act and in granting leave. Incorporating the perspective of the psychiatrist may have added further rich diversifying, or unifying insights into the experience of restrictive

practices. Purposive sampling may have avoided the absence of psychiatry. Purposive sampling could have also ensured that the demographics of the participants were representative of the sample population, for example regarding ethnic background and mental health diagnoses. Data regarding the ethnicity of patients admitted and staff members employed on these wards was regretfully not available. Additionally, convenience sampling may have unintentionally led to participants taking part who felt comfortable speaking to a researcher coming from outside of the hospital. There is a possibility that patients who are more mistrusting of professionals, due to previous experiences may not have volunteered to take part. This could have impacted on the results.

A further limitation to be acknowledged with the sample is that the staff members coming from different disciplines will have varying levels of responsibility for implementing restrictive practices, with some being directly involved and others only indirectly. Individual differences between staff members regarding the lived experience of implementing restrictive practices may have influenced the results as it may have led staff members to adopt varying approaches to the use of restrictive practices. For example, a staff member's seniority may lead them to have a different relationship to the use of restrictive practices than more junior members of the team. Additionally, the time that a staff member has worked on the ward for may also potentially impact on their views regarding restrictive practices, as they may have had increasing exposure to the effects of restrictive practices. These factors influencing the varying experiences of restrictive practices for staff may have impacted on the results in this study.

Methodological limitations included the restricted time that was available for the fieldwork component of the study. This was limited to a period spanning four

weeks, which reduced the opportunity for further enriching the data from the perspective of the observer. However, the researcher ensured that the fieldwork observations took place over a range of time points, such as daytime and evening and on different days of the week. This helped to broaden the observations made during the fieldwork, which included meal times, staff meetings, patient ward rounds, psychology groups, and general observations of the communal areas such as hallways and the TV room.

It was only identified that one of the wards taking part in the study was participating in a national programme to reduce restrictive practices once the research had commenced. Had this been known earlier, it may have influenced the design of the study, by utilising purposive sampling to include staff members involved in this programme, to explore whether any differences may be analysed across the two wards. However, the value of utilising ethnographic methods was that this development could be identified and acknowledged through the fieldwork component.

This qualitative study that explored one inpatient setting is not claiming to produce generalisable results to all inpatient psychiatric settings. However, the findings here are seen to relate to existing research and thus the findings can contribute to theoretical findings made elsewhere. As is appropriate when utilising ethnographic qualitative methods, the researchers have remained reflexive throughout the research process and acknowledge that the findings from the study will be shaped and informed by the context and approach taken by the researchers.

Implications for policy

A current focus within policy is placed upon reducing the use of restrictive practices (Care Quality Commission, 2017a; Department of Health, 2014; NHS Protect, 2013; Skills for Care and Skills for Health, 2014). This study supports the identified negative impact of restrictive practices on both patients and staff, and therefore supports the need to continue to reduce the use of restrictive practices. It also highlights the role that policies play in guiding and shaping staff members' delivery of care in this setting, as policies are identified by staff as legitimising the use of restrictive practices. The development of future policies regarding the use of restrictive practices should be co-produced incorporating the viewpoints of both staff and patients, in order to provide direction for the use of restrictive practices that aim to improve the experience of restrictive practices from the perspective of all stakeholders on the ward. It also highlights the need for policy to consider the experience of coercive and restrictive practices, as defined by the individuals involved.

Implications for clinical practice

This study has highlighted differences in the ways in which restrictive practices are made sense of and responded to by patients and staff. A particular divergence was that concerning the experience of 'de-escalation' techniques, which was analysed as being experienced at times as coercive by patients. This presents a key implication for staff involved in the delivery of de-escalation methods. For example, additional training in communication skills may support staff to work collaboratively with patients in the delivery of interventions aimed at preventing the use of restrictive practices as increasing levels of transparency in communication

when implementing de-escalation techniques may reduce the level of coercion experienced.

The study also identified the attempt made by staff to work empathically and humanely. Strengthening these skills and approaches across the multiple disciplines working in this setting would have clinical implications for supporting the improvement of the experience of care on the ward.

Clinical Psychology within the inpatient setting contributes to improved care, for example the introduction of team formulation meetings was analysed to improve staff understanding of patients, improve collaborative working and increase staff awareness of their own feelings, leading to reported improvements in relationships (Berry et al., 2017, 2016). This study was undertaken in one hospital site, through interviews with 57 staff members and 20 patients and as such the findings may be specific to this hospital site, however the larger sample size supports the transferability of the findings. Clinical Psychologists could utilise their skills in facilitating collaborative team formulation and reflective practice spaces to enable staff to reflect specifically on the use of restrictive practices, to emotionally process the 'sadness' or other emotional responses experienced and to reflect on the impact of restrictive practices on their clinical work and therapeutic alliance with patients.

Clinical Psychologists could also use their skills in delivering debriefing with staff and patients following incidences of restrictive practices. A recent scoping review found that immediate debriefing following seclusion or restraint was effective in providing support to staff (Mangaoil, Cleverley, & Peter, 2018). This could be built upon through the role of clinical psychology in supporting staff members to facilitate debriefs with patients involved in incidences of coercive practices, which

are defined by the patient, rather than solely being utilised following the more overtly coercive practices of seclusion or restraint.

In addition to debriefing practices, it may be beneficial for patients and staff to be supported to communicate to each other their experiences of restrictive practices and of de-escalation techniques. Increasing transparency and sharing of experiences may help to improve the implementation and lived experience of these practices. One way in which this may be achieved could be through the inclusion of these discussions in community meetings, which are attended by both staff and patients and provides space for all members of the ward to discuss their experiences. Further, patients could be provided with information when first admitted to the ward about practices that are utilised by staff and how staff make sense of and experience these practices. This may also serve to increase transparency and mutual understanding.

The perceived powerlessness experienced by patients, as demonstrated in the patient accounts of being part of an unwinnable game and feeling threatened by staff, may have implications for clinical psychology in relation to delivering psychological interventions in this setting. For example, a sense of powerlessness in the experience of symptoms of psychosis can lead to increased compliance with command hallucinations (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000). Psychological work in this setting could thus be supported by considering the impact of restrictive practices and de-escalation techniques. With admissions to inpatient psychiatric wards consisting of 62% of people experiencing a psychosis (Network, 2016), this may be particularly relevant to this setting.

An additional finding in this study was the recognition that clinical psychologists may not face the same challenges as staff members who are directly

involved in restrictive practices. Therefore, it may be crucial for clinical psychologists to be transparent about this difference and name this privileged position they occupy when working with members of staff to support them in their work, such as through the use of reflective practice sessions.

Implications for future research

Developing a deeper understanding of the ways in which experiences of care and restrictive practices diverge in the inpatient setting may play a central role in reducing the use of restrictive practices. A recent exploration of staff and patient perspectives on the therapeutic priorities of inpatient care concluded that the gap between staff and patient perspectives may explain the enduring dissatisfaction experienced by patients (Wood et al., 2019). This highlights the importance of gaining insight into the views and experiences of both patients and staff and analysing the potential impact that both similarities and differences in experiences may have. Building a more comprehensive understanding of the less overt and more subtle ways in which practices are experienced as restrictive or coercive will further develop understanding of the nature of these practices and will highlight adaptations that could be made to support the improvement of care and reduction of restrictive practices.

A need to gain a clearer understanding of the experience and efficacy of de-escalation techniques has already been noted (National Institute for Health and Care Excellence, 2015). This study supports this need for further research to examine the use of de-escalation strategies in this setting.

The findings from this study highlighted additional areas identified by participants as being related to their experience of restrictive practices, yet due to the

limited scope of the study it was not possible to fully explore all of these areas. For example, some patients spoke of the physical setting of the ward in shutting them off from the outside world, such as with windows that are unable to be opened and a lack of access to outdoor space and nature as playing an important role in their experience of feeling restricted on the ward and in negatively impacting on their wellbeing and impeding their recovery. Future research exploring the experience of restrictive practices in this setting may benefit from focusing on the experience of the physical setting of the ward and of the significance of gaining access to outdoor space. Additionally, within this study only one male staff member took part in the research. Future research may benefit from exploring if there are any differences in experiences of restrictive practices between male and female staff members as well as between male and female patients.

Conclusion

This study has offered further validation of what is already known about the experiences of restrictive practices within inpatient psychiatric care. It additionally offers a contemporary insight into the experience of both patients and staff under a current narrative of the aim to reduce the use of restrictive practices where possible. The study supports and corroborates other findings in the literature by providing a complex account of restrictive practices. Whilst restrictive practices are rationalised by patients and staff as necessary in order to ensure safety, the practices continue to be experienced negatively by patients and staff. The differences in experiences between patients and staff highlight a divergence in the use of approaches aimed at reducing the use of restrictive practices, whereby these continue to be experienced as restrictive and coercive measures by patients. This illustrates the need for further

research that allows for deeper exploration of the experience of strategies utilised in reduction programmes. A collaborative, co-produced approach including both staff and patients in the design and implementation of programmes to reduce restrictive practices would support the aim of reducing restrictive practices.

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Part 3: Critical Appraisal

Introduction

Within this critical appraisal I reflect upon the experience of undertaking the study presented in Part 2. A detailed diary was kept throughout the research process and this was referred to heavily in the writing of this appraisal. Additionally, a bracketing interview that was undertaken early in the research process further contributed to the reflections made here.

The critical appraisal begins by outlining the role of reflexivity within ethnographic research in order to situate the discussion. A reflection on the development of the study is outlined, focusing on the ways in which my previous experiences shaped the project. This is followed by a reflection on ethical dilemmas encountered during the data collection and analysis stages of the research. Reflections on my personal, professional and academic background are interwoven throughout.

Reflexivity within qualitative and ethnographic research

Reflexivity is a key component of ethnographic research and should occur continually throughout the research process (Mays & Pope, 1995). Reflexivity aims to provide a transparent account of the ways in which the research was shaped, for example in being shaped through the impact of the researcher, the use of specific methodological approaches or methods of data collection (Cruz & Higginbottom, 2013). Introduced as a response to a critique of qualitative research being viewed as biased (McCabe & Holmes, 2009), reflexivity has contributed to the growth and development of qualitative research (Finlay, 2002).

Within ethnographic research, the researcher plays a pivotal role in shaping both how the fieldwork develops and the form of the results (Goodwin, Pope, Mort,

& Smith, 2003). The role of the researcher is understood as being an active force in constructing the focus taken and the analysis of data selected (Finlay, 2008). Thus it is imperative within qualitative research to reflect on the possible ways in which the researcher may have shaped the study. 'Bracketing' is an effective tool to aid the process of reflexivity and can be utilised throughout the research process to support the researcher to consider and 'shelve' their own personal experiences and backgrounds (Fischer, 2009). The research diary and making use of supervision both assisted me in the use of 'bracketing' during the research process.

Development of the research project

Patient involvement

The bracketing interview identified a particular commitment to conducting research involving individuals who experience mental distress and who access mental health services. This interview highlighted the influence that a previous research project had on my desire to seek out further opportunities to conduct research that involves individuals with lived experience of accessing mental health services. The previous research project qualitatively explored service user experience of a community based psychology service. The participants expressed to me the value they had experienced from taking part and in having their opinions heard and I felt privileged to have been involved in helping to provide a platform for this sharing of their knowledge and experience. This experience fuelled my desire to seek out opportunities that promoted the involvement of service user participation in research.

In addition to this experience of conducting a study that focused on hearing the voices of service users, there is also a current drive within research and policy to increase the prevalence and quality of service user-focused research, either through

research conducted by service users, co-constructed research between service users and researchers, or research that involves service users as participants (Crisp, Smith, & Nicholson, 2016; Department of Health, 2012; Springham & Robert, 2015). Service user involvement in research has been attributed increased prominence in the development and evaluation of services, where emphasis has been given within policy to place patient involvement in the forefront of service evaluation and design, as well as hearing the voice of the patient at all levels of the system (Department of Health, 2012).

My commitment to involving patients in research influenced my desire to seek out a DClinPsy research project that supported this opportunity. During the process of acquiring a research project, I was on placement at the acute mental health hospital where this study took place. This placement was a challenging, yet rewarding experience for me. Having only previously worked within community-based settings, working within this closed setting was a new experience for me. Working with patients for the first time who were admitted under a section of the Mental Health Act, and who were often subjected to a range of restrictive practices whilst on the ward, I was struck by the challenge of delivering therapeutic care in this environment. This led me to explore existing research regarding the use and experience of restrictive practices in this setting.

During this placement, I undertook focus groups on the wards for my Service Related Research Project. This explored patient experience of activities on the ward. This research project gave me the opportunity to experience first-hand how patients valued participating in research projects that enabled them to provide feedback. I also witnessed the way in which the service implemented feedback from this project. This additionally contributed to my wish to conduct further research in this setting.

Patient and Public Involvement

Valuing the involvement of individuals with lived experience of accessing mental health services within research led me to seek guidance and input from the UCL Service User and Carer Committee during the design stage of the study presented in Part 2. Working with five consultants from the committee was an invaluable experience and their contribution to the development of the interview schedules and information sheets helped to ensure that the focus of the research was appropriate to the setting, to the population and to the research aims. In addition to supporting the development of research documents, feedback from one member highlighted contrasting ways in which similar questions were phrased differently across the two interview schedules, one of which was used with staff members and one of which was used with patients. This feedback helped me to reflect on the language used within the documents and to bring the two interview schedules more in line with each other. The feedback that the original phrasing of questions hinted towards an 'us and them' construction between professionals and patients helped me to reflect on the use of language.

Being a trainee clinical psychologist provides me with a particular lens via which the research is constructed. I actively strive in my work to limit the unnecessary use of jargon and to consider carefully the ways in which power inequalities can be present in the relationships between professionals and individuals who access services. Collaborating with the consultants provided me with the valuable experience of reflecting on these issues more deeply within the context of setting up a research project. This experience of working with the consultants also

reiterated the value and importance of receiving input from individuals who can bring differing perspectives to the research project.

Epistemological position and methodological approach

The bracketing interview highlighted to me the influence of previous academic learning and institutions I have attended. My undergraduate degree in Sociology and Theology makes me naturally curious about the broader context that shapes lived experience, rather than focusing solely on the internal world of individuals. Studying issues such as social inequality, discrimination and stigma within my undergraduate degree has made me alert to the experiences people may face on a macro-level. I have also gained a Masters in Psychology from the University of East London, which provided me with an introduction to both social psychology and critical psychology and epistemologies of social constructionism and critical realism. My MSc dissertation completed at UEL was informed by the philosophies of Foucault (Foucault, 1988, 2008) and Deleuze (Deleuze, 1990) whose work analyses the operations of power across all sections of society. Whilst not directly adopted as a theoretical lens in the present study, my interest in these accounts of structural experiences of power may have influenced my desire to undertake a research project that examines the experience of coercive practices in a closed setting.

I feel that these previous academic learning experiences significantly influenced the shape of the research project, in terms of adopting a critical realist epistemology and ethnographic methods, which allowed for an immersion in the context of the setting being explored.

Data collection and analysis

The completion of the research diary was particularly beneficial during the stages of data collection and analysis. This was a period that I found most brought up a wide range of emotional responses and challenging situations. Reflecting on these experiences in the journal helped me to process these experiences and to use the technique of 'bracketing off' my personal responses to prevent them from enshrouding the data.

Familiarity with the research setting

I came to this research with prior experience of working in this setting during a one year split placement that I completed one year before commencing the research project. This provided me with both advantages and disadvantages. Having prior experience of the research setting can support the setup of the research, through assisting with informal conversations with members of the field to establish rapport (Goodwin et al., 2003; Hammersley & Atkinson, 2007). The previous experience in this setting was also beneficial in terms of identifying an area of research that was relevant to the setting, in combination with reviewing literature and identifying existing gaps.

The researcher's understanding of the social setting within which the research is situated contributes to the ways in which a participant's experience is interpreted and understood by the researcher (Jootun, McGhee, & Marland, 2009). This highlights the active role that is played by the researcher's own experience of the setting under examination, in building an understanding of the data being collected. Thus having existing knowledge and experience of the ward setting would have influenced the ways in which I experienced and interpreted the data. This

relationship to the setting may bring advantages, as outlined above, however having a familiarity with the setting was also something to be cautious of as working on the wards would have unavoidably shaped my own personal ideas and feelings about the lived experience of being a member of the ward. Therefore, it was important for me to reflect on this and on the impact my previous work experience may have had. Holding this in mind, I worked closely with both of my supervisors during the design and implementation of the study to ensure that any preconceived ideas I may have held did not negatively affect the research.

Semi-structured interviews

Undertaking the semi-structured interviews raised certain challenges. Early in the research period, after the completion of the first interview, the interview transcript was reviewed by the lead supervisor. This provided the opportunity for feedback and guidance regarding the interview style. This discussion also helped me to reflect on my experience of undertaking the interview, before proceeding to complete further interviews. A key outcome of this procedure was the identification of how I was at times using a more therapeutic style of questioning, rather than a research-oriented approach. An example of this would be responding to a participant with an empathic statement, rather than with a follow up question. Using more follow up questions and taking a curious stance could have conveyed to the participant an empathic response, through showing an interest in hearing more about their experiences, as well as simultaneously exploring their response in more depth, which was an aim of the research. During the interview itself, I felt conflicted between a more familiar position for me as trainee clinical psychologist and a less familiar position of researcher. Due to the nature of the interviews often discussing

distressing experiences for the participants, I felt it was ethical and important to convey empathy. Empathy within research interviews can support the development of rapport between interviewer and interviewee and can assist the gathering of richer data, however caution is needed, as empathy can also lead to the assumption of shared understandings and commonalities which can serve to stifle the collection of data (Watson, 2009). Through guidance in supervision and employing self-reflection, I honed my research interview skills as the interviews progressed and feel this helped to improve the quality of the interviews, finding a balance between interviewing in a way that conveyed appropriate levels of empathy yet did not overly restrict the gathering of data.

The staff member interviews felt very different to the patient interviews, where I did not experience the conflict between embodying the role of therapist / researcher as intensely as during the patient interviews. Here, I felt that my previous experience of being a member of staff myself on the ward gave some familiarity and a shared language with the staff participants, which supported the building of a rapport between myself and the participants. However caution again was needed to ensure that terms used by the staff member participants were not taken for granted as being understood, but explored fully (Goodwin et al., 2003).

Fieldwork: Ethical dilemmas

As a novice ethnographic researcher, with no prior experience of undertaking fieldwork observations, I found this component of the study to be the most challenging. It therefore featured heavily in my research diary and an extract is given in this section below to explore my experience of carrying out the fieldwork.

Informed consent

Careful attention to the ethical considerations involved in facilitating observational fieldwork in this setting was required during the design stage of the research. Individuals admitted to the acute inpatient mental health hospital often experience their capacity to be compromised due to the high levels of distress they are experiencing. A consideration of the impact that the fieldwork may have on patients was carefully made by all members of the research team and by the ethics committee members. Measures were taken with the aim to reduce the possible sense of intrusion experienced by ward members as a result of the fieldwork. These included the positioning of posters clearly around the ward detailing the days and times that the fieldwork was scheduled to take place in order to forewarn members about my presence. A further strategy used was the wearing of a badge that clearly showed my name and my position as researcher. This was in attempt to demarcate me from members of staff.

An additional key way to navigate the ethical concerns regarding the undertaking of fieldwork observations in this setting was in the design of the study regarding the requirement for informed, written consent from participants. It was agreed that participants would be required to provide written consent for both the interview component and the fieldwork component of the research study. Only participants who had consented to take part in the interviews were invited to take part in and provide their consent for the fieldwork component. This ensured that participants were able to receive detailed information about the study before agreeing to take part in both components of the research, however it remained crucial to continually re-assess a participant's capacity to consent to the research throughout the period of fieldwork, as the process of giving consent is not static, but a dynamic

one (Seymour & Ingleton, 1999; Usher & Arthur, 1998).

An additional benefit to designing the study this way was that information gathered in the interviews could be either corroborated or questioned through the fieldwork observations involving the same participants (Griffin & Bengry-Howell, 2017). However, restricting the fieldwork observations to individuals who had taken part in the interviews and provided written consent significantly reduced the scope of the fieldwork observations, as other members on the ward were excluded from the fieldwork observations. Many incidences were observed during the fieldwork, which were relevant to the study, which could not be included as research data as they involved individuals who were not participants in the study. Although this limited the fieldwork observations, I feel that ensuring that those involved in the study were able to give fully informed consent was imperative and minimising the impact of the research on those who had not agreed to take part in the project was of paramount importance.

Role of the ethnographic researcher

One significant dilemma that I experienced during the period of fieldwork was captured in my research diary:

> Standing in the corridor during the fieldwork, a patient-participant is standing there and starts up a conversation with me. He seems frustrated, put out, more agitated than I've previously seen him. What's going on, I wonder? I look around the ward, the corridor is quiet, it feels settled at the moment. He tells me that his ward round is happening but that he has been "kept out". He tells me he doesn't know why and that he just wants to ask the doctor for some

> leave, that's all he wants, he says. He says his family can't come for the ward round and asks me if I will be his "independent person" and come with him to his next ward round. I instantly feel conflicted, and wonder how the participant views me, how he is relating to me. I can't be an 'independent person' or an advocate for the participant in his ward round. I feel I have to clarify my position to him when responding to his request. This leaves me wondering about the impact of this on the participant.

A reflection on the relationships between researcher and participants is central to qualitative research (Finlay, 2008). Following this situation, it was key to reflect on my relationship with the participant, in order to consider the ways in which this may impact on the participant and on the research and again supervision provided a useful space for facilitating this reflection.

In addition to feeling like a novice ethnographic researcher, I felt my presence on the ward during the fieldwork observations triggered questions about my role as a researcher and the impact this had on the participants, more so than the other two components of the study. In the extract above, I felt it was important to reiterate the boundaries of my role on the ward. The building of trust between ethnographic researchers and participants over time can aid the research process, however caution is needed to ensure that boundaries are upheld (Watts, 2008). I found the situation outlined above particularly challenging due to the conflict I experienced in how to respond to the situation. Being an advocate for patients has been part of my role as trainee clinical psychologist and in positions I've undertaken prior to clinical training. Thus it is deeply embedded within my professional identity and as such is difficult to relinquish this role in my present position as researcher

(Goodwin et al., 2003). I was unable to respond to this request made by the patient from the position of being an advocate, or as a trainee clinical psychologist. Having previously completed a placement at this hospital, I had prior experience of the value patients may experience from having an advocate support them in their ward rounds, and I had on occasion been this person for patients. However, this was not possible in the current situation and therefore presented a source of conflict for me. I responded to this situation by discussing with the patient about my role and the limitations to this and sought to clarify his understanding of the reasons for my presence on the ward.

It was also important to consider how my emotional response to this situation may have influenced the data collection and the analysis of this data. When writing up the data from this section of the fieldwork, I took time to stand back and consider whether my personal response was shaping the way in which the data was captured. Taking this additional time I felt helped to limit the amount that my personal experiences affected the data and the analysis of this data.

Mistaken identity

Reflecting on my identity during the fieldwork also brought with it other ethical dilemmas. During the fieldwork, I often felt conspicuous on the wards. I was neither patient nor staff member, although I felt I was viewed more closely to that of staff member. Being a relatively smartly dressed woman, wearing a name badge, a set of keys and a personal alarm, it was visibly clear to all that I was not a patient. Clearly on the male ward, I could not be viewed of as a patient and even on the female ward, my attire and access to things such as the keys and nursing station clearly demarcated me. Yet, I was not a staff member either. This was easily

ascertained by those on the ward when I was asked for support with various tasks, but failed to be able to help with these requests, which would come from both patients and staff. A conscious decision of how to present oneself in the field is a key task in preparing to undertake fieldwork (Hammersley & Atkinson, 2007). On reflection of my perceived identity to others on the ward, perhaps wearing more casual clothing may have reduced the chances of me being mistaken for a member of staff.

This misunderstanding of my role presented challenges. For example, whilst undertaking observations in the nursing station, I would sometimes be the only person in the room. This room is formed of glass windows so that nurses can have an easy view of the ward. Many times a patient would knock on the glass door or the window and make a request such as to access their mobile phone, which was on charge in the nursing station. On a practical level, it was clear to the patient and to myself that I could easily meet their request and pass them their mobile phone, as I had observed the staff to do on many occasions. However, as I was not a member of staff, I did not have the authority to do this. Although I would always explain this to the patient, at times the patient understandably would appear to find this frustrating. When reflecting on this situation, I noticed that I also felt frustrated by being unable to meet their need. I felt that I too was restricting the patient. It was important for me to reflect on the feelings that arose as a result of this, so that it did not influence the analysis. I felt aware that these experiences made me feel more aligned to staff members' reports of frustration and sadness at having to restrict patients and on occasion in not being able to meet their needs. It was crucial therefore to attempt to 'bracket off' my own assumptions and immerse myself in the data. Utilising

supervision to ensure that I was staying close to the data was highly valuable in maintaining credibility.

Undertaking ethnographic research in sensitive settings

Reflecting on and incorporating the emotional impact on the researcher of undertaking ethnographic research within sensitive settings is a key part of the research process (Watts, 2008). Exploring the lived experiences of restrictive practices from the perspectives of both patients and staff was expected to trigger emotional responses within myself as the researcher. Previous experience of working on the ward in part helped to prepare me for managing these emotional responses. My reflective research diary also became a key way in which I processed my personal responses during the research process and I also made use of supervision to further support this.

As can be seen from the themes documented in Part 2, the patient interviews were saturated with negative accounts of restrictive practices and the ways in which they experienced being subjected to restrictive practices. Careful consideration of how my emotional responses may impact on the analysis of the data was made and continually moving back and forth between the data collection and the analysis supported me in ensuring that the analysis was rooted in the data, rather than being overshadowed by my emotional responses. Additionally, as the analysis of the data began whilst data collection was continuing to be undertaken, I was presented with opportunities to verify information that was being identified from the interviews, which can be a useful way to identify differences or similarities in accounts (Fetterman, 1989). I found this back and forth between data collection and data

analysis a helpful way to remain grounded in the data and to 'bracket off' my personal responses to the experience of undertaking the research.

As the emotional responses of the ethnographic researcher are viewed of as being central to understanding the data (Watts, 2008), I also reflected on these emotional responses to pave a way into understanding the participants' accounts. Reflecting on my emotional responses and how my personal background and previous experiences may be informing these responses, I then re-examined the presenting insights into the data in the context of this background. This is a second engagement of bracketing and serves to reflexively consider the input of the researcher on the research data (Fischer, 2009).

One particular emotional response experienced during the research process was a sense of urgency to ensure that the participants' stories were effectively shared through the research in order to support the possibility of bringing about change. I was also particularly aware of the sense of wanting to acknowledge the dedication of staff to improving care for patients, which was witnessed both during the interviews and the fieldwork observations. Whilst undertaking the analysis, I was conscious of this feeling towards the data and reflected on this during supervision. Having additional researchers code the transcripts also ensured that we collectively remained close the data and that my personal experiences did not colour the analysis too greatly.

Conclusion

Undertaking ethnographic research within an acute inpatient mental health hospital raises numerous ethical dilemmas and is a challenging form of research. Navigating these dilemmas required a reflective stance to be adopted throughout the research process. The need to actively consider the role of the researchers in shaping

the research project in terms of aims, design, data collection and analysis is of significant importance in this methodological approach.

I found this research to be a highly stimulating and thought provoking experience and I feel privileged to have been a part of hearing participants' experiences. I feel that this research has offered an understanding of the lived experience of restrictive practices in the contemporary mental health ward. Despite the challenges involved in this type of immersive research, I have felt fortunate to have had the opportunity and this research experience has fuelled my desire to continue to undertake research projects that include and promote the voices of individuals involved in mental health services. The findings from this study highlight important implications for the delivery of inpatient psychiatric care, which may be of use across the multiple disciplines contributing to the care delivered in this setting. In relation to my own professional identity, this experience of undertaking the research will stay with me both personally, and in my future work as a Clinical Psychologist.

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Appendices

Appendix 1: Search Terms

Service user OR patient OR staff OR nurse OR psychiatrist OR psychologist
AND
Experience* OR conceptualization* OR thought
AND
Inpatient OR acute OR ward
AND
Mental health OR illness OR distress OR psychosis OR depression OR anxiety
AND
Restrictive practice* OR seclusion OR restraint OR coercion

Appendix 2: Health Research Authority Ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Vyv Huddy
Lecturer
University College London
1-19 Torrington Place
Fitzrovia
London
WC1E 7HB

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

26 November 2018

Dear Dr Huddy

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A study of psychiatric ward life: Exploring conceptions of care and experiences of restrictive practices.**
IRAS project ID:	**239990**
REC reference:	**18/LO/1593**
Sponsor	**University College London**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

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It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Nikkayla Dixon
Tel: [redacted]
Email: [redacted]

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **239990**. Please quote this on all correspondence.

IRAS project ID	239990

Yours sincerely

Simon Connolly
Senior Assessor

Email: [redacted]

Copy to: *Nikkayla Dixon, University College London*
Fiona Horton, North East London Foundation NHS Trust, Research and Development Department

IRAS project ID	239990

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Ward Poster]	1	15 October 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]		25 July 2018
HRA Schedule of Events	1	18 October 2018
HRA Statement of Activities	1	18 October 2018
Interview schedules or topic guides for participants [Interview Schedule follow up optional interview]	1	07 September 2018
Interview schedules or topic guides for participants [Interview Schedule]	1	20 July 2018
IRAS Application Form [IRAS_Form_05112018]		05 November 2018
Letter from sponsor [UCL Insurance confirmation letter]	13	30 July 2015
Letters of invitation to participant [Staff participant invitation email]	1	20 July 2018
Other [Principle Investigator CV]		
Other [Response to Provision Opinion 239990]	1	07 November 2018
Participant consent form [Staff member consent form Version 2]	2	20 October 2018
Participant consent form [Consent Form]	1	20 July 2018
Participant consent form [Consent Form Service user participant]	1	20 July 2018
Participant information sheet (PIS) [PIS Service User participant]	2	20 October 2018
Participant information sheet (PIS) [Participant Information Sheet]	1	20 July 2018
Participant information sheet (PIS) [Staff Member PIS Version 2]	3	09 November 2018
Referee's report or other scientific critique report [Peer review]	1	20 July 2018
Research protocol or project proposal [Protocol Version 2]	2	20 October 2018
Summary CV for Chief Investigator (CI) [CV]		
Summary CV for student [Student CV]		

IRAS project ID	239990

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	Observations will only be made where individuals have given consent.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No external funding application made.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
There will be a single participating NHS organisation, where the researcher will make observations of ward activities and undertake interviews with both staff and service users. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
There will be a principal investigator at the participating NHS organisation. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

IRAS project ID	239990

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Where arrangements are not already in place researchers undertaking research activities in NHS care facilities would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 3: Patient participant Information Sheet

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

UCL

Service user Participant Information Sheet

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: A study of psychiatric ward life: Exploring conceptions of care and experiences of restrictive practices.

Department: Research department of clinical, educational and health psychology

Student Researcher: Caroline Bendall Email: [redacted]

Principal Researcher: Dr Vyv Huddy Email: [redacted]

We'd like to invite you to take part in our research project studying the experience of care on an inpatient psychiatric ward. This is a student project as part of Caroline Bendall's Doctorate in Clinical Psychology. It is supervised by the principle researcher Dr Vyv Huddy.

Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the aim of the study?

This project aims to explore staff and service users' experience of inpatient mental healthcare, including practices that people may experience as restrictive, such as seclusion, physical restraints or chemical restraints (medication).

What does the study involve?

- The study will involve individual interviews with the researcher.
- It will also include fieldwork, where the researcher will be on the ward making observations for one to two hours per week for at least four weeks.
- The study will also review written documentation related to the provision of care on the ward, such as trust policies regarding the use of restrictive practices.

Why have I been chosen?

You have been invited to participate in this study because you are, or have been, a resident on a ward at Goodmayes Hospital. You have at least 24 hours to decide if you wish to take part. Individuals who cannot communicate in English, or have a moderate or severe learning disability and those who cannot provide informed consent are not able to take part in the study.

Do I have to take part?

- No. It is up to you to decide if you want to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.
- You can withdraw at any time without giving a reason and without it affecting any benefits that you are entitled to.
- Taking part in the study is entirely voluntary and if you decide not to take part, this will have no effect on the care or entitlements that you receive.

What if I want to stop taking part?

You have the right to withdraw your consent to take part in any part, or this entire research project, at any time.

Should you wish to withdraw from taking part, you can speak with the researcher, Caroline Bendall directly either in person during the fieldwork, or via email (address at top of this information sheet). Alternatively, you can speak to your named nurse or ward Clinical Psychologist. They will then let the researcher know that you no longer wish to take part. You will be fully compensated if you choose to withdraw.

If you decide to withdraw, any personal data you have provided up to that point will be deleted unless you agree otherwise.

What will happen to me if I take part?

Interviews

- You will take part in an individual interview with the researcher (Caroline Bendall).
- You will be asked to sign a consent form prior to undertaking the interview.
- The interview will last between 20 – 60 minutes.
- The interviews will be audio-recorded.
- You can stop at any point and you can choose not to answer any questions if you wish.

- You can also attend a follow up interview if you want to provide any more information.
-
- All interviews will be typed up and your name or any details which could identify you will be changed or deleted.
- The researchers will listen to all the interviews, identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report.
- If you would like a copy of the final research report you can contact the researchers Caroline Bendall or Dr Vyv Huddy (see contact details above).

Observations

- The researcher will be on the ward to make observations for 1 to 2 hours every week for at least 4 weeks.
- You may be on the ward during the observations.
- If you give consent, the researcher may join you in activities on the ward or meetings such as your ward round.
- All observation notes made by the researcher will not use your real name, so you cannot be identified.

Information about you

- The researcher will ask you about any mental health diagnoses and the length of your admission. If you do not know, the researcher may ask ward staff.

After the interview

- If you wish, you will be contacted following the study to be invited to take part in a focus group to talk about initial findings from the study.
- You will also have the choice whether or not you wish to be contacted to be invited to take part in any further research.

Will I be recorded and how will the recorded media be used?

Yes. The audio recordings of the interview will be used only for analysis. It is possible that some of your quotes will appear in the write up of the research, however this will not use your real name and you will not be identifiable. The audio recording will be kept securely on a password protected memory stick. Only the researchers will know the password and will have access to the data on the memory stick. Once the audio recording has been transcribed (typed on a computer) the audio recording will be destroyed. The transcription will also be kept securely on a password protected memory stick. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. The transcripts will be stored for 20 years in line with UCL policy and the General Data Protection Regulation. They may also be shared anonymously with researchers for future research.

What are the possible disadvantages and risks of taking part?

The interview will be asking about your experience of being on the ward, which may include both positive and negative experiences. It might feel upsetting to talk about negative experiences. Support from ward staff will be available should you want it after the interview. You can request to stop the interview at any point should you wish and there is no obligation to answer all of the questions you are asked.

If you feel distressed following the interview, you can contact the NELFT Mental Health Direct help line on: 0300 555 1000. This is open 24 hours per day and provides confidential support.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for people participating in the research, it is hoped that it will offer a useful chance for participants to provide feedback about their experiences. By sharing the findings from the research, we hope that it will contribute to developments within inpatient psychiatric care both within the hospital site and nationally.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. In the event you wish to complain contact the chief investigators using the details given below.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. Your real name will not be used in the write up of the research. You will not be able to be identified in any reports or publications of the research. All of your personal information will be handled in accordance with applicable data protection legislation.

Limits to confidentiality

Confidentiality will be maintained as far as it is possible. If during our conversation the researcher hears anything which makes her worried that someone might be in danger of harm, or she hears about a reportable serious event, she will inform relevant agencies of this as required.

What will happen to the results of the research project?

- The findings from this study will be presented as part of the researcher's Doctorate in Clinical Psychology.
- It may be shared through publication in journals, articles and at conferences. No personal identifiable information will be included.
- You can receive a copy of a summary of the findings if you wish.
- If you give consent, your interview transcript may be stored securely and confidentially at UCL premises with the possibility of being utilised for further research.

Data Protection Privacy Notice

University College London (UCL) is the sponsor for this study based in the United Kingdom. UCL will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

- UCL will keep identifiable information about you, such as your name and contact details, for six months after the study has finished.
- Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible.
- As a university we use personally-identifiable information to conduct research to improve health, care and services.
- As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study.
- Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.
- The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk.
- UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk.

Your personal data will be processed for the purposes outlined in this information sheet. The categories of personal data used will be as follows:

- Name
- Address
- Age
- Ethnicity
- Mental Health diagnoses (if applicable)
- Number of acute inpatient admissions and length of current admission

Under the General Data Protection Regulation, the legal basis that would be used to process your personal data will be performance of a task in the public interest.

You can provide your consent for the use of your personal data in this project by completing the consent form that has been provided to you.

Your personal data will be processed so long as it is required for the research project. Where possible we will use false names, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or you wish to make a complaint, please contact UCL Data Protection Officer, Lee Shailer in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

North East London NHS Foundation Trust (NELFT) will keep your name and contact details confidential and will not pass this information to UCL. NEFLT will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. NELFT will keep identifiable information about you from this study for 6 months after the study has finished.

Certain individuals from UCL and regulatory organisations may look at your medical and research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Who is organising and funding the research?

This research is taking place as part of the student researcher's (Caroline Bendall) doctorate in clinical psychology. It is supported by the host University, UCL, and North

East London Foundation NHS Trust, Research and Development Department. UCL is the study sponsor.

Who has reviewed the study?

All research in the NHS is reviewed by an independent group of people, called the Research Ethics Committee, which is there to protect your safety, rights and dignity. This project has been given a favourable review by the Research Ethics Committee and the Health Research Authority.

Who can I contact for more information?

If you require any further information, you can contact the Chief Investigator, Dr Vyv Huddy by email: [redacted] or telephone on [redacted]

You will be given a copy of the information sheet for your records, and be asked to sign a consent from before taking part.

Thank you for reading this information sheet.

Appendix 4: Patient Participant Consent Form

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

UCL

IRAS ID: 239990
Study Number: 18/0335
Participant Identification Number for this study:

CONSENT FORM – Service user participants

Title of Project: A study of psychiatric ward life: Exploring conceptions of care and experiences of restrictive practices.

Name of Researcher: Caroline Bendall

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

		Please Initial Box
1.	I confirm that I have read and understood the Information Sheet (Version 2, dated 20/10/18) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3.	I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from University College London (UCL) or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4.	I understand that my interview will be audio recorded.	
5.	I agree to take part in the above study.	
6.	I agree for my contact details to be retained for the duration of this research project, so that I can be invited to attend a focus group during the analysis phase to provide feedback on provisional findings.	
7.	I agree for my contact details to be retained so I can be contacted in the future by UCL researchers who may like to invite me to have the option to participate in follow up studies to this project, or in future studies of a similar nature.	
8.	I agree for my contact details to be retained so that I can be contacted with a copy of the findings.	

Name of Participant:	Date:	Signature:
Name of person taking consent:	Date:	Signature:

Appendix 5: Staff member Participant Information Sheet

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

UCL

Staff member Participant Information Sheet
IRAS ID: 239990

Title of Study: A study of psychiatric ward life: Exploring conceptions of care and experiences of restrictive practices.

Department: Research department of clinical, educational and health psychology

Student Researcher: Caroline Bendall Email: [redacted]

Principal Researcher: Dr Vyv Huddy Email: [redacted]

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

We'd like to invite you to take part in our research project studying the experience of care on an inpatient psychiatric ward. This is a student project as part of Caroline Bendall's Doctorate in Clinical Psychology. It is supervised by the principle researcher Dr Vyv Huddy.

Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the aim of the study?

This project aims to explore staff and service users' experience of inpatient mental healthcare, including practices that individuals may experience as restrictive, such as seclusion, physical restraints or chemical restraints (medication).

What does the study involve?

- The project will involve individual interviews with the researcher.
- It will also include fieldwork, where the researcher will be present on the ward making observations for one to two hours per week for at least four weeks.
- The study will also review written documentation related to the provision of care on the ward, such as trust policies regarding the use of restrictive practices.

Why have I been chosen?

You have been invited to take part in this study because you are a member of staff providing care to service users at Goodmayes Hospital. You have at least 24 hours to decide if you wish to take part. Individuals who can not communicate in English, or have a moderate or severe learning disability and those who can not provide informed consent are not able to take part in the study.

Do I have to take part?

- No. It is up to you to decide if you want to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- You can withdraw at any time without giving a reason.
- If you decide to withdraw, any personal data you have provided up to that point will be deleted unless you agree otherwise.
- Taking part in the study is entirely voluntary.

What will happen to me if I take part?

Interviews

- You will take part in an individual interview with the researcher (Caroline Bendall).
- You will be asked to sign a consent form prior to undertaking the interview.
- The interview will last between 20 – 60 minutes.
- The interviews will be audio-recorded.
- You can stop at any point and you can choose not to answer any questions if you wish.
- You can also attend a follow up interview if you want to provide any more information.
- All interviews will be typed up and your name or any details which could identify you will be changed or deleted.
- The researchers will listen to all the interviews, identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report.
- If you would like a copy of the final research report you can contact the researchers Caroline Bendall or Dr Vyv Huddy (see contact details above).

Observations

- The researcher will be on the ward to make observations for 1 to 2 hours at a time, for at least 4 weeks.
- You may be on the ward during the observations.

- All observation notes made by the researcher will not use your real name, so you cannot be identified.

Information about you

- The researcher will ask you how long you have worked on the ward.
- For service user participants, the researcher will gather information about their mental health diagnoses and length of their admission.

After the interview

- If you wish, you will be contacted following the study to be invited to take part in a focus group to talk about initial findings from the study.
- You will also have the choice whether or not you wish to be contacted to be invited to take part in any further research.

Will I be recorded and how will the recorded media be used?

Yes. The audio recordings of the interview will be used only for analysis. It is possible that some of your quotes will appear in the write up of the research, however this will not use your real name and you will not be identifiable. The audio recording will be kept securely on a password protected memory stick. Only the researchers will know the password and will have access to the data on the memory stick. Once the audio recording has been transcribed (typed on a computer) the audio recording will be destroyed. The transcription will also be kept securely on a password protected memory stick. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. The transcripts will be stored for 20 years in line with UCL policy and the General Data Protection Regulation. They may also be shared anonymously with researchers for future research.

What are the possible disadvantages and risks of taking part?

The interview will be asking about your experience of being on the ward, which may include both positive and negative experiences. It might feel upsetting to discuss negative experiences. You can request to stop the interview at any point should you wish and there is no obligation to answer all of the questions you are asked.

If you feel distressed following the interview, you can contact the NELFT Mental Health Direct help line on: 0300 555 1000. This is open 24 hours per day and provides confidential support.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for people participating in the research, it is hoped that it will offer a useful chance for participants to provide feedback about their

experiences. By sharing the findings from the research, we hope that it will contribute to developments in inpatient psychiatric care both within the hospital site and nationally.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. In the event you wish to complain contact the chief investigators using the details given below.

Will my taking part in this project be kept confidential?

All the information we collect during the course of the research will be kept strictly confidential. Your real name will not be used in the research. You will not be able to be identified in any reports or publications of the research. All of your personal information will be handled in accordance with applicable data protection legislation.

Limits to confidentiality

Please note that confidentiality will be maintained as far as it is possible. If during our conversation the researcher hears anything which makes her worried that someone might be in danger of harm, or she hears about a reportable serious event, then she will inform relevant agencies of this as required.

What will happen to the results of the research project?

- The findings from this study will be presented as part of the researcher's Doctorate in Clinical Psychology.
- It may be shared through publication in journals, articles and at conferences. No personal identifiable information will be included.
- You can receive a copy of a summary of the findings if you wish.
- If you give consent, your interview transcript may be stored securely and confidentially at UCL premises with the possibility of being utilised for further research.

Data Protection Privacy Notice

University College London (UCL) is the sponsor for this study based in the United Kingdom. UCL will be using information from you in order to undertake this study and will act as the data controller for this study. This means that UCL is responsible for looking after your information and using it properly.

- UCL will keep identifiable information about you for six months after the study has finished.
- Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.
- As a university we use personally-identifiable information to conduct research to improve health, care and services.
- As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study.
- Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.
- The data controller for this project will be UCL. The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk.
- UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk.

Your personal data will be processed for the purposes outlined in this information sheet. The categories of personal data used will be as follows:

- Name
- Address
- Age
- Ethnicity
- Length of time working on the ward at Goodmayes Hospital.

Under the General Data Protection Regulation, the legal basis that would be used to process your personal data will be performance of a task in the public interest.

You can provide your consent for the use of your personal data in this project by completing the consent form that has been provided to you.

Your personal data will be processed so long as it is required for the research project. We will anonymise or pseudonymise the personal data you provide, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or you wish to make a complaint, please contact UCL Data Protection Officer, Lee Shailer in the first

instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

North East London NHS Foundation Trust (NELFT) will keep your name and contact details confidential and will not pass this information to UCL. NEFLT will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. NELFT will keep identifiable information about you from this study for 6 months after the study has finished.

Certain individuals from UCL and regulatory organisations may look at your research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

What if I want to stop taking part?

You have the right to withdraw your consent to take part in any part, or this entire research project, at any time.

Should you wish to withdraw from taking part, you can speak with the researcher, Caroline Bendall directly either in person during the fieldwork, or via email (address at top of this information sheet). Alternatively, you can speak to the ward Clinical Psychologist. They will then let the researcher know that you no longer wish to take part. You will be fully compensated if you choose to withdraw.

Who is organising and funding the research?

This research is taking place as part of the student researcher's (Caroline Bendall) doctorate in clinical psychology. It is supported by the host University, UCL, and North East London Foundation NHS Trust, Research and Development Department. UCL is the study sponsor.

Who has reviewed the study?

All research in the NHS is reviewed by an independent group of people, called the Research Ethics Committee, which is there to protect your safety, rights and dignity. This project has been given a favourable review by the Research Ethics Committee and the Health Research Authority.

Who can I contact for more information?

If you require any further information, you can contact the Chief Investigator, Dr Vyv Huddy by email [redacted] or telephone on [redacted]

You will be given a copy of the information sheet for your records, and be asked to sign a consent from before taking part.

Thank you for reading this information sheet.

Appendix 6: Staff Member Participant Consent Form

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

IRAS ID: 239990
Study Number: 18/0335
Participant Identification Number for this study:

CONSENT FORM – Staff member participants

Title of Project: A study of psychiatric ward life: Exploring conceptions of care and experiences of restrictive practices.

Name of Researcher: Caroline Bendall

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

		Please Initial Box
1.	I confirm that I have read and understood the Information Sheet (Version 2, dated 20/10/18) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3.	I understand that the data collected during the study may be looked at by individuals from University College London (UCL) or from the NHS Trust, where it is relevant to my taking part in this research.	
4.	I understand that my interview will be audio recorded.	
5.	I agree to take part in the above study.	
6.	I agree for my contact details to be retained for the duration of this research project, so that I can be invited to attend a focus group during the analysis phase to provide feedback on provisional findings.	
7.	I agree for my contact details to be retained so I can be contacted in the future by UCL researchers who may like to invite me to have the option to participate in follow up studies to this project, or in future studies of a similar nature.	
8.	I agree for my contact details to be retained so that I can be contacted with a copy of the findings.	

Name of Participant:	Date:	Signature:
Name of person taking consent:	Date:	Signature:

Appendix 7: Patient Participant demographics

Pseudonym	Age	Ethnicity	Gender	Mental Health Diagnosis	Length of admission	Total number of admissions
Chris	38	White Irish	Male	Paranoid Schizophrenia	7 months	4
Isaac	26	Black British	Male	Paranoid Schizophrenia	10 days	3
Karl	30	White British	Male	Psychosis Post-traumatic stress disorder	2 weeks	2
Malik	22	Mixed British	Male	Suggested diagnosis of Paranoid Schizophrenia	5 months	1
Joseph	27	British African	Male	Schizophrenia	10 weeks	4
Mary	58	White Irish	Female	Personality Disorder Schizophrenia Depression Anxiety	2 weeks	6
Aisha	23	British Pakistani	Female	Bipolar Disorder	1 week	Unknown
Munira	25	Black British African	Female	Depression Post-traumatic stress disorder	3 weeks	Unknown
Sarah	39	White British	Female	Complete PTSD Depression Psychosis	2 weeks	3

Appendix 8: Staff Member Participant demographics

Pseudonym	Ward (Male / Female)	Job title	Length of time working on ward	Age	Ethnicity	Gender
Mara	Male	Mental Health Nurse	4 months	37	Black African British	Female
Anita	Male	Clinical Lead	10 years	48	Black African British	Female
Leena	Male	Student Mental Health Nurse	6 weeks placement	40	Black African British	Female
Harry	Male	Health Care Assistant	1 year	50	Black African British	Male
Yalina	Male	Ward Administrator	3 years	50	British Pakistani	Female
Kate	Female	Mental Health Nurse	5 months	36	Black African British	Female
Barbara	Female	Support Worker	2 years	36	Black African British	Female
Sophie	Female	Assistant Psychologist	1 year 4 months	23	White British	Female

Appendix 9: Patient Participant Interview Schedule

Interview Schedule – Service User Participants

Introduction

- Introduce self and the project
- Outline confidentiality and complete consent form
- Ask the participant what they wish to be called
- Discuss any questions or concerns the participant may have

Engagement

- Would you like to tell me a bit about yourself, where you're from etc

General experience of ward life

- How are you finding life on the ward?
    - How long you have been on the ward?
    - Is this your first time or have you stayed here before?
    - What is your overall impression of your time on the ward?
    - How do you spend your day?
    - What are the highlights of your day?
    - What are the lowlights of your day?
    - Have there been any particular events that have happened that stand out to you?
    - What was significant about this for you?

Experience of care on the wards

- How do you define 'care'?
    - In what ways does this match the care you have received here?
    - In what ways does it not match the care you have experienced here?
    - What is the most important thing about 'care' for you?
    - What care have you received whilst you've been here?
    - Has that helped you and if so, in what way?
    - If it hasn't helped you, why do you think that is?
    - How do you feel when you get this care?
    - What do you think the staff think care is/means?

Relationships / communication

- How have you experienced communicating with staff on the ward?
    - Can you tell me about one positive interaction with staff?
        - What was involved in this interaction that made it a positive one for you?
        - What impact did this interaction have for your time on the ward?
    - Can you tell me about one negative interaction with staff?
        - What was involved in this interaction that made it a negative one for you?

        - What impact did this interaction have for your time on the ward?

Experience of restrictive practices

- What has your experience been of restrictive practices?
    - Have you ever been asked to do something on the ward that you didn't want to?
    - Have you ever been treated in a way that you didn't want to be treated?
    - Have you wanted to do something on the ward but not been able to?
    - How did this feel?
    - Sometimes service users might become upset when they are on the ward. If you have seen this, how have you experienced staff responding to this? What do you think of what happened? How did it make you feel?
    - Who carries out the restrictive practices?
        - Staff / other service users

General ending questions

- Is there anything else you want to tell me about your experience of being on the ward?

Appendix 10: Staff Member Participant Interview Schedule

Interview Schedule – Staff Member participants

Introduction

- Introduce self and the project
- Complete consent form and outline confidentiality
- Ask the participant what they wish to be called
- Discuss any questions or concerns the participant may have

Engagement

- Would you like to tell me a bit about yourself, where you're from etc

General experience of ward life

- How are you finding working on the ward?
    - Can you tell me how long you have worked on the ward?
    - What is your overall impression of your time on the ward?
    - How do you spend your day?
    - What are the highlights of your day?
    - What are the lowlights of your day?
    - Have there been any particular events that have happened that stand out to you?
    - What was significant about this for you?

Perceptions of 'care'

- How would you define care?
    - What factors are the most important part of 'care'
    - How do you feel your role is related to the delivery of care on the ward?
    - Is there anything that helps or hinders you to act in ways that support you to deliver caring interventions within your role?
    - What do you think service users believe care to be?

Relationships / communication

- How have you experienced communicating with service users on the ward?
    - Can you tell me about one positive interaction you have experienced with service users?
        - What was involved in this interaction that made it a positive one for you?
        - What impact did this interaction have for your time on the ward?
    - Can you tell me about one negative interaction you have experienced with service users?
        - What was involved in this interaction that made it a negative one for you?
        - What impact did this interaction have for your time on the ward?
- How have you found communicating with other staff members on the ward?

Experience of restrictive practices

- What helps you to manage challenging behaviour on the ward?
- What makes it difficult to manage behaviour that challenges?
- In your experience, what do you think is the most effective way to manage challenging behaviour?
- What impact does managing challenging behaviour have on you?
- What impact do you think it has on the service user involved, and for other service users?

Duties

- What duties or tasks are prioritised in your role?
- What duties take up most of your time?
- What would you like to do more of?
- What would you like to do less of?

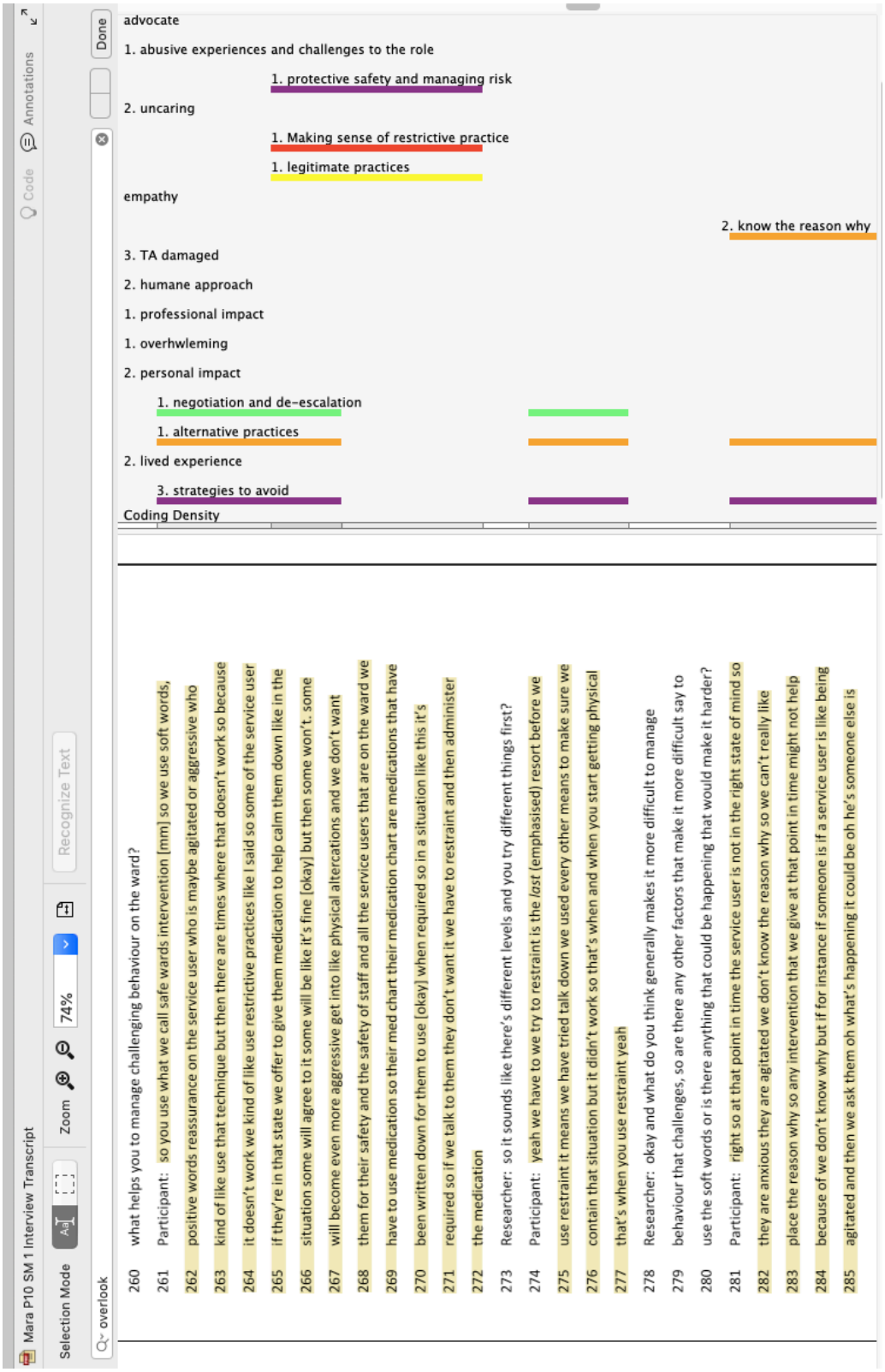
General ending questions

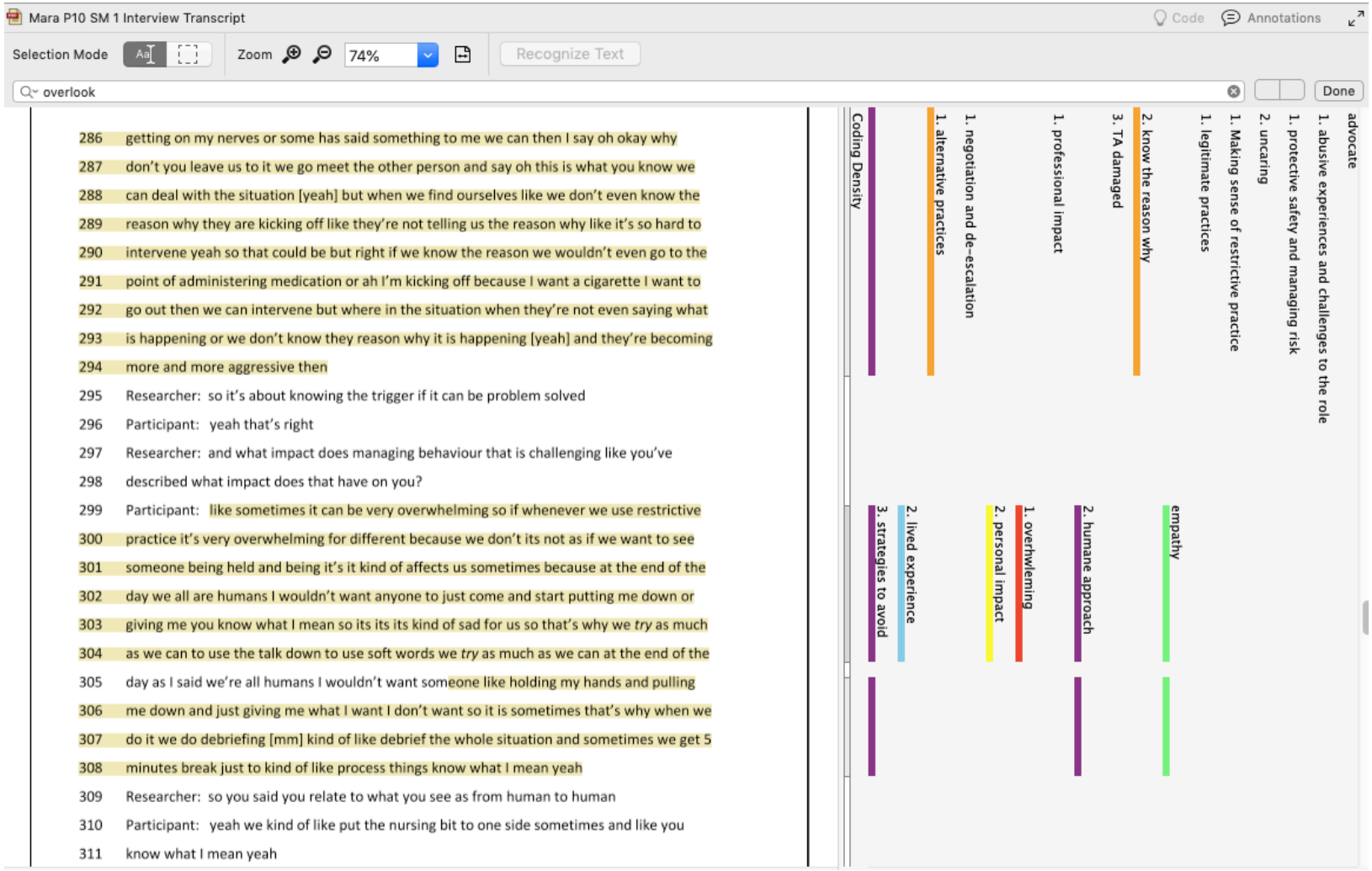
Is there anything else you want to tell me about your experience of being on the ward?

Appendix 11: Transcription Codes

Function of Transcription Coding	**Example**
Indicate brief hesitation in speech	(.)
Moments of hesitation more than 1 second put number of seconds inside the round brackets	(2)
Indicate brief response to participant in square brackets	[hm]
Indicate main speaker laughing	{LAUGHS}
Indicate extract beginning part way through speech	[…]
Indicate section of extract removed	…
Indicate shouting by underlining and capitalize	<u>STUPID</u>
Indicate unfinished spoken work with dash	Analy-
Indicate identifiable information removed	{NAMES EMPLOYER}
Indicate information entered to clarify what participant is referring to	*{restraint}*

Appendix 12: Coded Transcript extract




Mara P10 SM 1 Interview Transcript
Code
Annotations
Selection Mode
Zoom
74%
Recognize Text
overlook
Done
286 getting on my nerves or some has said something to me we can then I say oh okay why
287 don't you leave us to it we go meet the other person and say oh this is what you know we
288 can deal with the situation [yeah] but when we find ourselves like we don't even know the
289 reason why they are kicking off like they're not telling us the reason why like it's so hard to
290 intervene yeah so that could be but right if we know the reason we wouldn't even go to the
291 point of administering medication or ah I'm kicking off because I want a cigarette I want to
292 go out then we can intervene but where in the situation when they're not even saying what
293 is happening or we don't know they reason why it is happening [yeah] and they're becoming
294 more and more aggressive then
295 Researcher: so it's about knowing the trigger if it can be problem solved
296 Participant: yeah that's right
297 Researcher: and what impact does managing behaviour that is challenging like you've
298 described what impact does that have on you?
299 Participant: like sometimes it can be very overwhelming so if whenever we use restrictive
300 practice it's very overwhelming for different because we don't its not as if we want to see
301 someone being held and being it's it kind of affects us sometimes because at the end of the
302 day we all are humans I wouldn't want anyone to just come and start putting me down or
303 giving me you know what I mean so its its its kind of sad for us so that's why we try as much
304 as we can to use the talk down to use soft words we try as much as we can at the end of the
305 day as I said we're all humans I wouldn't want someone like holding my hands and pulling
306 me down and just giving me what I want I don't want so it is sometimes that's why when we
307 do it we do debriefing [mm] kind of like debrief the whole situation and sometimes we get 5
308 minutes break just to kind of like process things know what I mean yeah
309 Researcher: so you said you relate to what you see as from human to human
310 Participant: yeah we kind of like put the nursing bit to one side sometimes and like you
311 know what I mean yeah
Coding Density
1. alternative practices
1. negotiation and de-escalation
1. professional impact
3. TA damaged
2. know the reason why
1. legitimate practices
1. Making sense of restrictive practice
2. uncaring
1. protective safety and managing risk
1. abusive experiences and challenges to the role
advocate
3. strategies to avoid
2. lived experience
2. personal impact
1. overhwleming
2. humane approach
empathy

Appendix 13: Early analysis coding

Staff Member analysis 1

Nodes

Name	Files	References
abused by patients but this will pass	2	6
assaults	3	4
bored	2	2
Care	0	0
achieving the patients' goals	2	2
appreciate care at the end	2	2
Barriers to providing care	0	0
demanding patients	2	3
don't know care at the start	5	10
don't have capacity	1	1
overlook inability to view it as care	1	1
best practice	1	1
care as a core value of nursing	2	2
collaborative	1	4
compassion	1	3
continuity of care	2	2
counselling	1	1
daily living	2	2
follow through on promises	5	8
challenging behaviour	3	3
care plans	7	10
need to understand the behaviour	2	3
overwhelming	2	3
conflicting	1	1
culture	1	1
different professional perspectives	1	1
disappointment of not meeting needs	1	1
discharge	2	4
don't rush the care	1	2
encroaching on their rights	1	1
engagement	4	6
Environment	0	0
busy	1	1
changeable environment	1	1
extra time	1	2
freedom	1	1
frustration for patients	6	11
functioning	1	1
holistic care	1	1
physical health	2	4
illness causes the difficulties, not the person	1	2
individualised care	4	9
investment	1	1
justified by CQC	1	1
knocking on nursing station	2	2
lack of provision reducing quality of care	1	1
learn from the patients	1	1
limited resources	1	2
looking after staff wellbeing	1	1
love my job	2	2
managers visible	1	1
medical model dominant	1	1
medication	6	14
meet needs in a timely manner	4	5

May 9, 2019

May 9, 2019